IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B. CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTN P. by his next friend, LINDA C. BAYLIS. By her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)
Plaintiffs,	)
v.	)NO. 3-98-0168)Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)
Defendants.	)

JANUARY 2000 SEMI-ANNUAL PROGRESS REPORT

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B. CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTN P. by his next friend, LINDA C. BAYLIS. By her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)
Plaintiffs,	)
vi.	)NO. 3-98-0168)Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)
Defendants.	)

JANUARY 2000 SEMI-ANNUAL PROGRESS REPORT

Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the state Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel

regarding their compliance with the terms of this order. Such reports are to be filed on July 31st and January 31st of each year. Said reports "shall contain information, validated by the applicable audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order..."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending January 31, 2000. This Report contains the following components:

1. Overview of activities during report period
2. Attachment A: EPSDT Outreach and Informing Survey
3. Attachment B: Summary of Outreach for Each TennCare Plan and Spreadsheet of Activities
4. Attachment C: Hearing, Vision, Developmental and Behavioral Screening Guidelines
5. Attachment D: EPSDT Pilot Study: Le Bonheur Children's Medical Center
6. Attachment E: Summary of MCO Case Management Activities
7. Attachment F: Revised Remedial Plan (Draft)
8. Attachment G: TennCare Standard Operating Procedure 036 Addenda 2 and 3
9. Attachment H: Progress Towards EPSDT Targets
10. Attachment I: Department of Children's Services EPSDT and Dental Screens Report

Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' local counsel.

Semi-annual Progress Report

EPSDT Consent Decree

January 31, 2000

Table of Contents

OVERVIEW

Efforts to ensure compliance with the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) Consent Decree as well as to increase public awareness of EPSDT benefits are ongoing. The Bureau of TennCare and the Department of Children's Services (DCS) are committed to improving the delivery of EPSDT services to their consumers. An overview of the State's progress for the period of August 1, 1999, through January 31, 2000, is contained in this Semi-annual progress report.

During the past six months several activities occurred that were not specifically required by the EPSDT Consent Decree but which nevertheless will have an impact on the issues identified in the decree. These activities include the following:

- **Grant for outreach activities**. The Robert Wood Johnson Foundation awarded a grant of $991,648 to the Tennessee Health Care Campaign (THCC) to support activities especially designed to increase enrollment of children in TennCare. Several urban and rural counties serve as research sites for this project. A Statewide Advisory Committee has been created to assist the Statewide Coordinator in this project. The TennCare for Children Statewide Advisory Committee has met several times and they are focusing on increasing TennCare enrollment of children, maintaining enrollment, and encouraging the use of TennCare services, including EPSDT services. The Committee is utilizing the Social Marketing "Logic Model" for outlining the steps to achieve their goals.

- **Early Child Health Outreach (ECHO).** The Tennessee Health Care Campaign (THCC) has also received a grant from the Nathan Cummings Foundation to begin a new program called Early Child Health Outreach. The ECHO program is focused on outreach and education to parents of children birth to six whose children are insured though TennCare. ECHO will educate parents about their children's right to EPSDT benefits and about their right to a medical appeal if these health screenings are denied by a managed care organization (MCO) or behavioral health organization (BHO). The ECHO program complements the TennCare for Children project, which focuses on reaching eligible, uninsured children for enrollment in TennCare.

- **TennCare Shelter Enrollment Project.** The National Health Care for the Homeless Council administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. Since 1998, the Project has provided TennCare outreach enrollment training to more than one hundred emergency shelter staff in twenty-two Tennessee counties, both rural and urban. In the last six months their statewide outreach activities have included a focus on regional EPSDT education and training. The Project has been successful in developing groundbreaking community-level collaborations among stakeholders including: the Bureau of TennCare, homeless and domestic violence shelters, MCOs, BHOs, local county health departments, TennCare transportation providers, the Department of Human Services (DHS), and homeless families residing in emergency shelters.

- **Education/Training**. During the past six months several presentations on TennCare and EPSDT have been conducted for various organizations such as the Tennessee Conference on Social Welfare (TCSW), the Tennessee Early Intervention System (TEIS), the TennCare Shelter Enrollment Project and for the Office of Minority Health.

- **EPSDT Task Force of Davidson County .** The Davidson County EPSDT Task Force was established last summer and is represented by members of the health care community representing Davidson county including: BHOs, MCOs, advocacy organizations, the Metropolitan Davidson County Health Department and the Bureau of TennCare. The task force has come together to network with related agencies and to draw upon the resources and energy of stakeholder agencies to facilitate and strengthen efforts to build awareness about EPSDT in Davidson County. It is hopeful that the success of this task force will encourage other counties to develop a similar task force and replicate the efforts of this task force statewide.

- **Interagency Agreements.** TennCare has been working with the Departments of Education (DOE), Mental Health and Retardation (DMHMR), Children's Services, and Human Services DHS to develop a comprehensive interdepartmental agreement for children with disabilities. This agreement incorporates definitions used by each department, services provided by each department, and a description of special activities to be conducted around early intervention. A dispute resolution process is being finalized, after which time the agreement will be complete. This agreement should be very helpful in resolving problems and making sure that each department is aware of services offered by other departments and how to access these services for children.

Major Accomplishments during the Period

1. **Monitoring of outreach and informing activities.** *(Paragraph 39)* The Quality Oversight Unit has completed a survey (See Attachment A) to determine the extent of MCO outreach and informing activities. A check sheet that listed all the required components of an outreach and informing program was sent to each MCO with a letter requesting that the check sheet be completed and documentation to support the activities submitted to the Bureau. The internal tracking system for each MCO was also reviewed to determine if pending due dates and past due dates for preventive services could be identified for each member.

   A spreadsheet was developed that included each element of outreach and informing activities to provide a comprehensive overview of each MCO program. In addition, the MCOs submitted member newsletters, flyers, brochures, and literature from community events. Summaries of each TennCare plan's EPSDT outreach and informing strategies and the spreadsheet can be found in Attachment B.

   The Unit is currently reviewing all documentation to determine that each plan has devoted adequate resources to fulfill contractual requirements. Any MCO that is noted to have areas that need further development will be required to bring that area into compliance.

2. **EPSDT Guidelines Committee.** *(Paragraph 44)* The EPSDT Screening guidelines Committee completed vision and hearing screening guidelines and behavioral and developmental guidelines (See Attachment C) as required by the EPSDT Consent Decree. The guidelines have been widely distributed to MCO/BHO medical directors, EPSDT coordinators, the Pediatric Society of Tennessee and to the Tennessee Nursing Association (TNA). The guidelines have also been included in past EPSDT semi-annual progress reports and in TennCare Standard Operating Procedures (TSOPs) both of which are distributed to the MCOs/BHOs and their providers and other state agencies such as the Department of Health (DOH), DHS, DCS, and DMHMR. A contract with Le Bonheur Children's Medical Center in the amount of $22,008, was executed and finalized in order to field test the hearing, vision, behavioral and developmental guidelines. The pilot study began mid-July and was completed August 1999. The study was conducted in two local pediatric practices in Shelby County, Tennessee, to examine, in clinical practices, the subjective and objective recommendations of the screening instruments proposed by the EPSDT Guidelines Committee.

   A total of 209 children were screened during the course of the pilot study. (See Attachment D.) The clinical impression of the recommended screening instruments has been positive, however, provider feedback suggested concerns about the financial impact of the recommended changes, impact on access to care, training and education, and documentation.

   Dr. Michael Myszka, Director of Psychology Services for the Bureau of TennCare, and Joseph McLaughlin, Ph.D., Chair of the EPSDT Guidelines Committee, are currently drafting an introduction to the recommended guidelines, which will define the purpose of the Committee, technical criteria and research studies used in the selection of screening instruments, the authority of the Consent Decree and address other areas of concerns that were raised during the Committee meetings. Upon completion, the introduction will be forwarded to the MCOs/BHOs for distribution to their providers. There are also plans to distribute the letter of introduction and the recommended guidelines through other medical and behavioral health, professional organizations.

3. **Monitoring of MCO case management activities.** *(Paragraph 70)* MCO case management programs are continually being developed. Eight MCOs have continuing case management and orientation programs for their staff. Member education regarding case management services is provided through newsletters and/or member handbooks at eight MCOs. One MCO conducts a case management certification class for their staff. All MCOs measure performance against predetermined benchmarks or are in the process of including the measure in their program. Another MCO has a community resource manual that lists self-help groups, mental health services, vision and hearing services, housing and day care services. See Attachment E for a summary of case management activities for each MCO.

4. **Submission of a remedial plan to address problems in delivering health care to children in State custody.** *(Paragraph 92)* The State continues to develop proposals and have included the plaintiffs' counsel in this process with the goal of reaching mutual agreement on

a remedial plan to be submitted for the Court's approval. Paul DeMuro, a consultant who was agreed upon by both parties has facilitated the negotiation process and Health Commissioner, Dr. Fredia Wadley, has taken on the task of spearheading the current plan. (See Attachment F.) The State anticipates submitting a finalized remedial plan to the Court by mid-February 2000. The plan outlines the following activities

- Development of a Best Practice Network (BPN) which refers to a group of providers (primary care, behavioral health, and dental) to provide EPSDT screenings and appropriate care for children in DCS custody.
- Development of Best Practice Guidelines.
- Establish Centers of Excellence (COE's) to develop care plans for the most complex cases of children in custody, provide care to children with the most critical needs and to provide consultation to local providers.

5. **Services testing on a sample of plaintiff class members**. *(Paragraph 99)* East Tennessee State University (ETSU) was chosen to conduct an analysis of a random sample of the entire TennCare population of children and adolescents to determine whether they have received necessary diagnoses and medical/behavioral treatment in conformity with the requirements of the Consent Decree. A draft of the study entitled "An Evaluation of Health Care Services in the Pediatric TennCare Population" was submitted to the Bureau of TennCare January 2000, and is currently being reviewed. This study includes an analysis of the information obtained by telephone from family members and other individuals who may know the child, an over-sampling and focus study of children with chronic illnesses requiring special medical attention, as well as an analysis of information relating to the diagnosis and treatment abstracted from medical records. The investigators rigorously studied the reliability of the expert medical reviewers (all physicians) and found a high rate of inter-rater agreement. Some of the key findings include but are not limited to the following:

- ***Appropriateness of diagnosis and treatment.*** The study included an extensive medical record review to determine the appropriateness of services. The study reports that out of the more than 3000 diagnostic and treatment services recorded in the medical records, the reviewers judged 92% of recorded treatments to be appropriate while only three percent were judged to be inappropriate. The other 5% could not be determined.
- **Specialist referrals**. Overall, in the review or medical records, 5.4% of the diagnostic events led to a specialist referral. Eighty-nine percent of the children's medical records show no evidence of difficulty obtaining referrals to specialists and only 1% suggests a problem.
- **Parent's satisfaction of health care services received by their children.** Ninety percent of the adult caretakers were satisfied with the services provided by their children's PCP. Eighty-four percent of the caretakers with children referred to a specialist were satisfied with the care provided by specialists and 84% were satisfied with care received from their local county health department.
- **EPSDT services.** The adult caretaker interview found that 87% of the caretakers did not know the meaning of EPSDT, however 26% said that they were "somewhat familiar" with their children's TennCare plan's benefits.

- **Untreated health problems.** Both the parent interviews and medical record reviews found a very low rate (4%) of untreated health problems in the pediatric TennCare population.
- **TennCare services.** An examination of the details of the different components of services received by the children from their PCPs and other health care providers suggests that children covered by TennCare received good services. This is confirmed by caregiver reports and medical record reviews.

6. **Policy clarification and interpretation.** *(Paragraph 100)* TennCare Standard Operating Procedure (TSOP) 036 Addendum 2, which addresses Coordination of EPSDT services was published in August 1999. This TSOP included an attachment of the statewide list of services for which EPSDT coordination is appropriate. TSOP 36 Addendum 3 clarifies the EPSDT screening requirements and was published November 1999. (See Attachment G.) The TSOPs provide policy clarification on the EPSDT mandate and outreach and informing requirements.

7. **Review of Appeals.** *(Paragraph 101)* The former Appeals Unit has been reorganized and renamed the TennCare Solutions Unit. Due to the implementation of the revised Consent Decree (Grier vs. Wadley) which governs TennCare appeals, the recent reorganization of the Appeals unit and the recent move to a different location, the regular appeals report is unavailable at this time due to technical difficulties with the data tracking system however, the report is expected to be available shortly.

   A number of systems and process changes are being implemented which will facilitate additional monitoring and analysis of EPSDT related appeals data. Data on the following indicators will be utilized from the appeals database and analyzed and/or reported on the following schedule. This process will begin on or before March 1, 2000 with the first complete quarterly report being shared in July.

	Every 2 weeks	Monthly	Quarterly	Semi-Annually	Annually
Total # of EPSDT denials	X	X	X	X	X
Total # of EPSDT denials by MCO/BHO	X	X	X	X	X
Total # of BHO denials resulting in state custody	X	X	X	X	X
Denials sorted by type of service, plan, and region	X	X	X	X	X
Decisions sorted by type of service, plan and region		X	X	X	X
Number of overturns sorted by service, plan and region	X	X	X	X	X
Analysis of data for patterns of denial by type of service, plan, or region.		X	X	X	X

	Every 2 weeks	Monthly	Quarterly	Semi-Annually	Annually
Reporting of patterns to Quality Oversight and Contract Compliance for action		X	X	X	X
Sharing of analysis information with plans			X		
Reporting for Progress Report				X	

- The bi-weekly analysis will be utilized for early identification of potential patterns of denials.
- The monthly analysis will be utilized to strengthen or confirm identification of patterns of denials.
- The monthly reporting of identified patterns of denial to Quality Oversight and Contract Compliance will allow for two things. First, Quality Oversight can conduct a more detailed study of the services being denied to see if similar patterns are present in non-appeal cases. Second, Contract Compliance can review and where appropriate assess monetary penalties, fines or damages against plans where a pattern of inappropriate denial of EPSDT services exists.
- Quarterly, semi-annual and annual analysis of information will allow for monitoring of patterns over time to determine if seasonal or other factors impact denials of specific services.
- Quarterly sharing of analysis information with plans will help alert them to potential problems in time to make necessary internal process changes.

Until new processes and systems are in place, information will be collected on a daily basis, and manual analysis will occur on as many of the indicators as feasible on a monthly basis.

8. **Screening compliance for Federal Fiscal Year 1997.** *(Paragraphs 45 and 46)* The baseline percentage of overall screening compliance for Federal Fiscal Year 1996 was 21.9%. The percentage of overall EPSDT screening compliance for Federal Fiscal Year 1997 is 24.6%. The overall-screening ratio reported to the Health Care Finance Administration (HCFA) on the 416 report for 1997 was 45%. A medical chart review conducted by the Quality Improvement Unit at TennCare was used to determine the percentage of all 7 components that were actually documented in a sample of records; the percentage for 1997 was 54.82%. Applying this percentage to the ratio obtained from the 416 report yields 24.6%, which is the adjusted periodic screening percentage (APSP). (See Attachment H.) The overall-screening ratio reported to HCFA on the 416 for 1998 was 39%.

The baseline percentage of dental screening compliance for Federal Fiscal Year 1996 was 28.2%. The dental screening percentage (DSP) for 1997 is 31.1%. There were 142,402 dental screens reported on the 1997, HCFA 416 report for children in the age groups from 1-20. The expected number of dental screening services was calculated using HCFA

methodology and determined to be equal to 457,253 screens. Since dental screens are not recommended until age 3, the actual number of dental screens (142,402) was divided by the expected number of screens (457,253) and the result was 31.1%. The DSP for 1998 is 30.8%.

9. **Enhanced monitoring of discharge planning for psychiatric and chemical dependency facilities.** *(Paragraph 71iii)* The Quality Oversight Unit in conjunction with a representative from the behavioral health organizations continues to conduct medical record reviews at psychiatric inpatient facilities/residential treatment facilities. The purpose of the review is to determine if there is collaboration, coordination and continuity of care in all aspects of the discharge process.

   Six medical record reviews were conducted in Chattanooga, Memphis and Nashville, Tennessee during the period from November 1999 through January 2000. The failure to obtain a release of information from the consumer in order to forward the medical record to the primary care provider was the most common deficiency identified during the medical record review. The Quality Oversight Section requested plans of correction from the BHOs. The plans of correction have been reviewed and accepted.

10. **Summary of EPSDT screens for children in DCS custody.** *(Paragraph 52)* DCS continues to track EPSDT screenings for children in custody. A report, which provided a summary of screenings, effective 9/11/99 indicated that 92.7% of children in custody have received an EPSDT screen. (See Attachment I).

    During the months of September and October, data on children served by DCS was converted to a new information management system (TNKids). Not all of the twelve regions converted simultaneously; conversion was staggered. Data pulled from the old information system as of the end of September indicated screenings at 88.6%; data pulled from the new information system indicated 76.7%.

    DCS is providing information to its regions so that child-specific information can be reviewed for data accuracy. The DCS Policy, Planning and Research division has developed a data cleaning schedule so that EPSDT screening data can be reviewed and corrected on a monthly basis, and data in monthly reports can be verified for accuracy.

Attachment A

EPSDT Outreach and Informing Survey

EPSDT OUTREACH AND INFORMING SURVEY

The Bureau of TennCare and its MCO's and BHO's are required to inform all TennCare enrollees under 21 about the availability of and how to access EPSDT services. This should be accomplished in a timely manner, generally within 60 days of the MCO/BHO's receipt of notification of the child's TennCare eligibility. Please attach all documentation that supports your outreach and informing activities regarding EPSDT.

Please include methods of communication:

Oral			Written		
Outreach representative	yes_	no_	New member letter	yes_	no_
Provider relations	yes_	no_	Member newsletter	yes_	no_
Public service announcement	yes_	no_	Posters, flyers, brochures	yes_	no_
Community awareness program	yes_	no_	Member handbook annually	yes_	no_
Member services representative	yes_	no_	Returned mail is tracked	yes_	no_

Timeframe for sending new member letter:
Actions taken to address returned mail:

Individuals to be informed:

Parent/guardian of newly eligible child	yes_	no_	Families in WIC program	yes_	no_
TennCare eligible pregnant women	yes_	no_	Administrator of institution	yes_	no_

Procedures in place to contact members who are: (Please explain)
Blind –
Illiterate-
Deaf-
Non-English speaking-
What is the process in place to monitor the effectiveness of these procedures?

Submit any documentation of coordination with other programs such as:

Head Start	AFDC
Educational systems	Day Care Licensing Agency
WIC	Health department

Internal Tracking System

Internal tracking system is in place?	yes_	no_
Can past due EPSDT services for each member be determined?	yes_	no_
Can pending service due dates be determined?	yes_	no_

What is method used for member notification?

Please include:
Policy outlining mechanism of documentation of attempts to contact member regarding EPSDT services, and documentation of EPSDT services that are declined.
Copies of last 4 member newsletters.
Policy for distribution of posters and brochures
BE 10/99

Attachment B

Summary of Outreach for Each TennCare Plan and Spreadsheet of Activities

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: JEAN McIVER R.N.

DATE: 12/30/99

RE: SUMMARY OF ACCESS MedPLUS HEALTH CARE EPSDT OUTREACH AND INFORMING ACTIVITIES

Access MedPlus informs members about EPSDT services available through New Member Notification Letter and also through distribution of brochures, e.g."New Generations," "Be Wise ....Immunize," and "Preventive Health." Other methods of communication are through Provider relations and Member services representative. AMP also sends New Member Notification Letters, as well as their annual Member Handbook. AMP does coordinate with other programs, e.g. Head Start, WIC, Health Departments, and Tenn Care Shelter Enrollment Project. AMP has in place an Internal Tracking System to monitor members who are past due for EPSDT services which allows the generation of a reminder letter to be sent to the enrollee.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: Kasi Tiller

FROM: Barbara Evans, RN

DATE: 12/27/99

RE: **Summary of BlueCare EPSDT Outreach and Informing Activities**

BlueCare has developed 3 different types of oral member orientation methods because all members do not comprehend information in the same way. They have a member orientation video (an overview of BlueCare and EPSDT benefits), a healthy bingo (health topics in the place of numbers), and a member orientation session conducted by field service representatives. Field service reps also participate in Immunization Fairs at the request of the health departments.

Written communication programs include proactive member and provider components. The member component includes postcards that are mailed to the parent or guardian of a member one month prior to the ages of the American Academy of Pediatrics periodicity schedule. The provider notification is a list sent to primary care managers of their assigned members who were sent a member notification postcard.

Bright Futures program is an incentive based program for new and expectant moms with the purpose of teaching mothers the importance of EPSDT. Applications are available at health departments, DHS, Housing Manager Offices, and provider offices.

The BC Bear Cub Club is a school-based program to teach healthy habits to children in kindergarten through third grades. Teachers are given teacher's guides, which include health activities, and children receive a BC Bear Cub Club booklet.

Field service representatives also make quarterly visits to homeless shelters, health departments, foster parent associations, group homes, and public housing developments. In addition to the external contacts, BlueCare also established the Hispanic Task Force (to develop health education programs for the Hispanic community), and an EPSDT Task Force (to obtain input and collaborate with other MCO's, health departments, and patient advocates on issues related to improvement of the EPSDT compliance rate).

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: MART DOWDEN, RN

DATE: 12/27/99

RE: SUMMARY OF JOHN DEERE HEALTH CARE EPSDT OUTREACH AND INFORMING ACTIVITIES

John Deere Health Care informs members about EPSDT services available through distribution of brochures, e.g. "Preventive Care Program," "New Generations," and "Be Wise...Immunize." Public Service announcements informing members of EPSDT services are played for callers waiting after dialing the Member Services number. New Member Letters and quarterly "health Talk" newsletters also inform members of available EPSDT services. JDHC has a comprehensive "2000 Timeline" Action Plan for monitoring areas of Member Education, Provider Education, PCP Access and Availability, and Compliance Reporting. This Action Plan focuses on specific recommendations, areas of responsibility, priorities and target dates for completion. JDHC has in place an Internal Tracking System to monitor members who are past due for EPSDT services which allows the generation of a reminder letter to be sent to the enrollee.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: MART DOWDEN, RN

DATE: 12/27/99

RE: SUMMARY OF MEMPHIS MANAGED CARE/TLC EPSDT OUTREACH AND INFORMING ACTIVITIES

TLC has developed a number of methods to encourage the use of EPSDT services. Outreach efforts include the distribution of Member Newsletters, Preventive Care Guidelines and maintains a comprehensive Brochure Distribution List. TLC participates in Health Fairs and Clinics in collaboration with Memphis and Shelby County Health Department Immunization Council and the TennCare Shelter Enrollment Project. Brochures and incentives for members to utilize EPSDT services include, but are not limited to; TLC Preventive Health Services Brochure, EPSDT Brochure, "Shots For Tots" Reminder Cards, Growth and Development Planner, The Facts About Immunization Brochure. TLC utilizes an "Enhanced Risk Appraisal program (EHRA) and a "Well-Chek," (Ages 14 and above), assessment tool to encourage enrollees to maintain current positive health behaviors. TLC conducted a 1998 Immunization Study of Twenty-Four Month Old Children to ascertain adherence to the Centers for Disease Control (CDC) immunization guidelines for children reaching their second birthday. Results of the study were reported to the TLC Medical Advisory Committee in August 1999. TLC has reviewed provider compliance with EPSDT at selected sites in their service area with results reported to the provider, the provider aggregate of peers and the TLC Medical Advisory Committee.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

DATE: December 28, 1999

TO: Kasi Tiller

FROM: Patrick Baumann RN

SUBJECT: Summary OF OmniCare EPSDT Outreach and Informing Activities

OmniCare informs their members about EPSDT services through a new program called "OmniKids". This program will facilitate obtaining complete information on children who are enrolled in the program, ages birth through six years. OmniCare also informs members by using mailings, newsletters, health-o-grams, and surveys. OmniCare has a partial internal tracking system in place. They can determine past due EPSDT services, and have a policy outlining the mechanism of attempts to contact members regarding EPSDT services that are declined. OmniCare uses posters and brochures that are printed in multiple languages such as Arabic, Spanish, Somolian, Vietnamese, and Bosnian. There are also procedures in place to contact members who are blind, illiterate, and deaf. Omnicare has a process in place to monitor the effectiveness of these procedures. Omnicare is making progress towards accomplishing, in a timely manner, the child's TennCare eligibility and setting in motion the program of EPSDT for its members.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: CAROL MIONE, RN

DATE: 12/28/99

RE: SUMMARY OF PERFERRED HEALTH PARTNERSHIP OF TENNESSEE, INC. (PHP) EPSDT OUTREACH AND INFORMING ACTIVITIES

In January 1999, PHP delegated all quality improvement of its EPSDT functions to Tennessee Health Partnership (THP) following a downsizing. PHP is in the process of refining the oversight of these delegated functions. The Academy of Pediatrics preventive guidelines for children and contractually required EPSDT guidelines were adopted by PHP and distributed to their providers in October 1998. Numerous methods of communication were used to encourage the use of EPSDT services. Outreach efforts include the distribution of Member Handbooks, member service representatives, community awareness programs, physician office education agenda, quarterly member newsletters ("Take Five") and school IEP process. All areas of written communication were used by THP, including sending new member letters within one week of receiving eligibility and actions to address returned mail. All individuals were informed, such as parent/guardian, eligible pregnant women, families in WIC program, school administration and health departments. THP is in the process of establishing a Preventive Service Database capable of generating notices to members, and has identified January 28, 2000, as the target date for implementation. This database would enable the delegated organization to notify members of pending or past due EPSDT services. Newsletters are sent out quarterly with the last one sent out the third quarter of this year. Again PHP/THP are in transition due to the dramatic downsizing of PHP and the delegation of quality improvement to THP. Both organizations are working diligently to improve the EPSDT Program.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: JEAN McIVER R.N.

DATE: 12/30/99

RE: SUMMARY OF PRUDENTIAL HEALTH CARE EPSDT OUTREACH AND INFORMING ACTIVITIES

Prudential Health Care informs members about EPSDT services available through A quarterly member newsletter, community awareness program, annual Member Handbook, and brochures. Prudential Health Care has in place an Internal Tracking System to monitor members who are past due for EPSDT services which allows the generation of a reminder letter to be sent to the enrollee.

As of December 31, 1999, Prudential Health Care will no longer be a Tenn Care provider.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER
FROM: CAROL MIONE, RN
DATE: DECEMBER 28, 1999
RE: SUMMARY OF XANTUS EPSDT OUT REACH AND INFORMING ACTIVITIES

Xantus has developed different modes to encourage enrollees to use EPSDT services. Included in their outreach effort is the distribution of 1999 Members Handbook, explaining EPSDT services and timelines, quarterly member newsletters (last mailed Spring 1999 with draft of Fall 1999 reviewed), "Coming Attractions Club" to educate expecting parents in the care of their anticipated arrival and the "Birthday Club" reminding enrollees to get preventive health exams/services. Some of the outreach material provided by Xantus for review was dated 1998 as well as some policies and procedures were not dated or approved and others were only in draft form. All methods of oral and written communication were used, but the only non-English speaking used was Spanish. Procedures were in place for communication with members with special needs, except no documentation revealed any form of communication available for illiterate enrollees. Hedis 3.0 software was implemented this year for an internal tracking mechanism to assist the Quality Improvement department to identify specific preventive services rendered, due and past due. A draft copy of an "EPSDT Services Provided" form has been developed and once approved will be distributed to all providers in an effort improve EPSDT compliance among providers. A member of the Quality Improvement department participates on EPSDT Davidson County Task Force and the TennCareShelter Enrollment Project.

Xantus is striving to improve all aspects of EPSDT by identifying the population in need, developing a successful outreach program, and implementing a new internal tracking system. Xantus is also working with other MCOs and health care delivery systems to achieve a higher rate of compliance, as well as mirror the efforts of the Davidson County EPSDT Task Force throughout the state.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

DATE: December 28, 1999

TO: Kasi Tiller

FROM: Patrick Baumann RN

SUBJECT: Summary OF VANDERBILT COMMUNITY CARE EPSDT OUTREACH AND INFORMING SURVEY

Vanderbilt Community Care informs their members about EPSDT programs through a wide range of services that include community awareness programs, member services representatives, posters, flyers, brochures, new member letters, annual member handbook, and outreach representatives. VHP identifies members that are TennCare eligible from birth up to age 21. VHP monitors the effectiveness of the EPSDT Program by using birthday mailers, Medical Treasure Passport for Life, phone calls, quarterly newsletters, community outreach activities such as WIC Program, Head Start, Health Department, AFDC, and by informing educational systems i.e. "Day Care Centers and Schools. VHP has an internal tracking system in place that can determine pending service due dates and past due EPSDT services. VHP has a program that will in January 2000, systematically notify all EPSDT eligible members and their families about services and benefits. VHP EPSDT Program also includes a procedure to contact members who are blind, deaf, illiterate, and identifies non-English speaking families and provides them with the appropriate information in their language. VHP'S survey is concise, easy to follow, and demonstrates their willingness to provide members with a program that is fully functional and readily available to all TennCare eligible members and their families.

Memorandum

To: Kasi Tiller

From: BHO Quality Oversight Division

Date: 12/29/99

Re: Summary of Tennessee Behavioral Health EPSDT Outreach and Informing Activities

---

TBH has used many different types of oral communication such as outreach representatives, provider relations, community awareness programs and member services representatives in order to provide information to members and the community in general. TBH has facilitated training sessions and workshops for providers statewide, as well as field representatives facilitating regional planning meetings with the providers to discuss needs specific to their region.

Written communication programs for TBH include new member letters, member newsletters, an annual member handbook, and a newly developed system that tracks returned mail. TBH has developed policies and procedures to support this new tracking system.

The parents/guardians of children that are newly eligible receive information about EPSDT when they receive a new member letter as well as a member handbook, which explains the EPSDT process. In addition, administrators of institutions are informed of EPSDT through a copy of the provider manual, which all administrators receive.

TBH coordinates with outside agencies such as Tennessee Voices for Children, TDMHMR Children's Issues Committee, Tennessee Medical Association, the Family Violence and Homeless Shelters in Tennessee and participates in the EPSDT Task Force.

TBH has developed an internal tracking system that will track any complaints, compliments and grievances regarding EPSDT. Furthermore, any past due EPSDT services for each member can be determined through their computer system for members with special behavioral health needs.

Memorandum

To: Kasi Tiller

From: BHO Quality Oversight Division

Date: 12/29/99

Re: Summary of Premier Behavioral Systems EPSDT Outreach and Informing Activities

---

Premier has used many different types of oral communication such as outreach representatives, provider relations, community awareness programs and member services representatives in order to provide information to members and the community in general. Premier has facilitated training sessions and workshops for providers statewide, as well as field representatives facilitating regional planning meetings with the providers to discuss needs specific to their region.

Written communication programs for Premier include new member letters, member newsletters, an annual member handbook, and a newly developed system that tracks returned mail. Premier has developed policies and procedures to support this new tracking system.

The parents/guardians of children that are newly eligible receive information about EPSDT when they receive a new member letter as well as a member handbook, which explains the EPSDT process. In addition, administrators of institutions are informed of EPSDT through a copy of the provider manual, which all administrators receive.

Premier coordinates with outside agencies such as Tennessee Voices for Children, TDMHMR Children's Issues Committee, Tennessee Medical Association, the Family Violence and Homeless Shelters in Tennessee and participates in the EPSDT Task Force.

Premier has developed an internal tracking system that will track any complaints, compliments and grievances regarding EPSDT. Furthermore, any past due EPSDT services for each member can be determined through their computer system for members with special behavioral health needs.

MCO/BHO EPSDT OUTREACH AND INFORMING SURVEY

METHODS OF ORAL COMMUNICATION

	OUTREACH REPRESENTATIVE	PROVIDER RELATIONS	PUBLIC SERVICE ANNOUNCEMENT	COMMUNITY AWARENESS PROGRAM	MEMBER SERVICE REPRESENTATIVE		
ACCESS MED PLUS	X	X	X	X	X		
BLUE CARE	X	X	O	X	X		
J0HN DEERE	O	X	X	O	X		
OMNI	X	X	O	X	X		
PHP	X	X	O	X	X		
PRUCARE	X	X	O	X	X		
TLC	X	X	O	X	X		
VHP	X	O	O	X	X		
XANTUS	X	X	X	X	X		
PREMIER	X	X	O	X	X		
TBH	X	X	O	X	X		

METHODS OF WRITTEN COMMUNICATION

	NEW MEMBER LETTER	MEMBER NEWSLETTER	POSTERS, FLYERS, BROCHURES	MEMBER HANDBOOK ANNUALLY	RETURNED MAIL TRACKED	TIMEFRAME FOR SENDING NEW LETTER	TAKEN TO ADDRESS RETURNED
ACCESS MED PLUS	X	X	X	X	X	X	X
BLUE CARE	X	X	X	X	X	X	X
J0HN DEERE	X	X	X	X	X	X	X
OMNI	O	X	X	X	X	X	X
PHP	X	X	X	X	X	X	X
PRUCARE	X	X	X	X	X	X	X
TLC	X	X	X	X	X	X	X
VHP	X	X	X	X	X	X	X
XANTUS	X	X	X	X	X	X	X
PREMIER	X	X	O	X	X	X	X
TBH	X	X	O	X	X	X	X

X=submitted documentation
O=documentation not submitted
N/A= not apr e

MCO/BHO EPSDT OUTREACH AND INFORMING SURVEY

INDIVIDUALS TO BE INFORMED

	PARENT/ GUARDIAN OF NEWLEY ELIGIBLE CHILD	TENNCARE ELIGIBLE PREGNANT WOMEN	FAMILIES IN WIC PROGRAM	ADMINISTRATOR OF INSTITUTION			
ACCESS MED PLUS	X	X	X	X			
BLUE CARE	X	X	X	X			
J0HN DEERE	X	O	O	X			
OMNI	X	X	X	O			
PHP	X	X	X	X			
PRUCARE	X	X	O	O			
TLC	X	X	O	O			
VHP	X	X	X	X			
XANTUS	X	X	X	X			
PREMIER	X	N/A	N/A	X			
TBH	X	N/A	N/A	X			

PROCEDURES IN PLACE TO CONTACT MEMBERS WHO ARE:

	BLIND	ILLITERATE	DEAF	NON-ENGISH SPEAKING	PROCESS IN PLACE TO MONITOR THE EFFECTIVENESS OF THESE PROCEDURES		
ACCESS MED PLUS	X	X	X	X	X		
BLUE CARE	X	X	X	X	X		
J0HN DEERE	O	O	X	X	X		
OMNI	X	X	X	X	X		
PHP	O	O	O	O	O		
PRUCARE	O	O	O	O	O		
TLC	X	O	X	X	X		
VHP	X	X	X	X	X		
XANTUS	X	O	X	X	O		
PREMIER	X	X	X	X	X		
TBH	X	X	X	X	X		

X=submitted documentation
O=documentation not submitted
N/A= not ap ble

MCO/BHO EPSDT OUTREACH AND INFORMING SURVEY

DOCUMENTATION OF COORDINATION WITH OTHER PROGRAMS SUCH AS:

	HEAD START	EDUCATIONAL SYSTEMS	WIC	AFDC	DAY CARE LICENSING AGENCY	HEALTH DEPT.
ACCESS MED PLUS	X	X	X	X	X	X
BLUE CARE	X	X	X	X	X	X
J0HN DEERE	O	O	X	O	O	X
OMNI	O	X	X	O	O	X
PHP	X	X	X	X	X	X
PRUCARE	X	X	X	X	X	X
TLC	O	O	X	O	O	X
VHP	X	X	X	X	X	X
XANTUS	X	O	X	X	X	X
PREMIER	X	X	N/A	N/A	N/A	X
TBH	X	X	N/A	N/A	N/A	X

INTERNAL TRACKING SYSTEM

	TRACKING SYSTEM IN PLACE	CAN DETERMINE PAST DUE EPSDT SERVICES	CAN DETERMINE PENDING SERVICE DUE DATE	METHOD USED FOR MEMBER NOTIFICATION
ACCESS MED PLUS	X	X	X	X
BLUE CARE	X	X	X	X
J0HN DEERE	X	X	X	X
OMNI	X	X	X	X
PHP	O	O	O	O
PRUCARE	X	X	X	X
TLC	X	X	X	X
VHP	X	X	X	X
XANTUS	X	X	X	X
PREMIER	X	X	X	X
TBH	X	X	X	X

X=submitted documentation
O=documentation not submitted
N/A= not ap ble

MCO/BHO EPSDT OUTREACH AND INFORMING SURVEY

SUBMITTED POLICY OUTLINING MECHANISM OF DOCUMENTATION OF ATTEMPTS TO CONTACT MEMBER REGARDING EPSDT SERVICES, AND DOCUMENTATION OF EPSDT SERVICES THAT ARE DECLINED							
ACCESS MED PLUS	X						
BLUE CARE	X						
J0HN DEERE	X						
OMNI	X						
PHP	O						
PRUCARE	O						
TLC	X						
VHP	X						
XANTUS	X						
PREMIER	X						
TBH	X						

SUBMISSIONS

	LAST FOUR MEMBER NEWSLETTERS	POLICY FOR DISTRIBUTION OF POSTERS AND BROCHURES					
ACCESS MED PLUS	X	X					
BLUE CARE	X	O					
J0HN DEERE	X	X					
OMNI	X	X					
PHP	X	O					
PRUCARE	O	O					
TLC	X	X					
VHP	X	X					
XANTUS	X	X					
PREMIER	X	O					
TBH	X	O					

X=submitted documentation
O=documentation not submitted
N/A= not applicable

Attachment C

Hearing, Vision, Developmental and Behavioral Screening Guidelines

Recommendations of the TennCare EPSDT Screening Guidelines Committee
Hearing and Vision Screenings
January 1999

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
Newborn	• Parental perception of hearing • Family history • Wakes to loud noises • Head turning with voice/noise	• ABR or OAE, if performed in hospital • Observational screening with noisemaker (optional)		• Eye exam: red reflex, corneal inspection
2-4 days	• Parental perception of hearing • Family history • Responses to voice and noise—parent report	• ABR or OAE, if performed in hospital • Observational screening with noisemaker (optional)		• Eye exam: red reflex, corneal inspection
By 1 month	• Parental perception of hearing • Family history (unless previously recorded) • Response to voice and noise—parent report	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam: red reflex, corneal inspection • Fixes on face, follows with eyes
2 months	• Parental perception of hearing • Family history (unless previously recorded) • Response to voice and noise—parent report	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam: red reflex, corneal inspection • Fixes on face, follows with eyes
3 months	• Parental perception of hearing	• Ear exam • Observational screening	• Parental perception of vision	• Eye exam • Fixes and follows each eye

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
	• Family history (unless previously recorded) • Response to voice and noise—parent report	with noisemaker (optional)		
4 months	• Parental perception of hearing • Recognizes parent's voice—parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
6 months	• Parental perception of hearing • Turns to sounds—parental report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
9 months	• Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
12 months	• Parental perception of hearing • Response to voice and noise—parent report • Family history (unless otherwise recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
15 months	• Parental perception of hearing • Response to voice and noise—parent report • Family history (unless	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision • Can see small objects	• Eye exam • Can see small objects

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
	previously recorded)			
18 months	• Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision • Can see small objects	• Eye exam • Can see small objects
24 months	• Parental perception of hearing • Response to voice and noise—parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision • Can see small objects	• Eye exam • Can see small objects
3 years	• Parental perception of hearing	• Ear exam • Hearing screen (optional) • Observational screening with noisemaker (optional)	• Parental perception of vision • Can see small objects	• Eye exam • Ocular alignment, visual acuity (optional) • Can see small objects
4 years	• Parental perception of hearing	• Ear exam • Hearing screen (if not done at 3 years)	• Parental perception of vision	• Eye exam • Ocular alignment, visual acuity (if not done at 3 years)
5 years	• Parental perception of hearing	• Ear exam • Hearing screen (if not done at 3 or 4 years)	• Parental perception of vision	• Eye exam • Ocular alignment, visual acuity (if not done at 3 or 4 years)
6 years	• Parental perception of hearing	• Ear exam • Hearing screen (if not done at 3, 4, or 5 years)	• Parental perception of vision	• Eye exam • Ocular alignment, visual acuity (if not done at 3, 4, or 5 years)
7 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen	• Parental and patient perception of vision	• Eye exam
8 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done	• Parental and patient perception of vision	• Eye exam

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
		at 7 years)		
9 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7 or 8 years)	• Parental and patient perception of vision	• Eye exam
10 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, or 9 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity
11 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, 9, or 10 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 10 years)
12 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, 9, 10, or 11 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 10 or 11 years)
13 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, 9, 10, 11, or 12 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 10, 11, or 12 years)
14 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen	• Parental and patient perception of vision	• Eye exam • Visual acuity
15 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14 years)
16 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14 or 15 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14 or 15 years)
17 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14, 15, or 16 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14, 15, or 16 years)

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
18 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14, 15, 16, or 17 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14, 15, 16, or 17 years)
19 years	• Parental and patient perception of hearing	• Ear exam	• Parental and patient perception of vision	• Eye exam
20 years	• Parental and patient perception of hearing	• Ear exam	• Parental and patient perception of vision	• Eye exam
21 years	• Parental and patient perception of hearing	• Ear exam	• Parental and patient perception of vision	• Eye exam

HEARING SCREENING

- Newborn hearing screenings are most likely to occur in hospital with results reported to the primary care provider. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAE) with thresholds of 30 dB HL.
- Newborn hearing screening is recommended for all newborn infants. As of January 1999, not all hospitals in the State have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003.
- Recommended testing intervals: The committee recommends an objective hearing screening test once in each of the following age ranges: 3-6, 10-13, 14-18. Screening should be conducted at the first visit during the above listed intervals at which the patient is cooperative.
- Acceptable methods of objective hearing screening include: conventional audiometry, hand-held audiometry, conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000 Hz).
- Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

VISION SCREENING

- Recommended testing intervals:
    - The committee recommends testing ocular alignment and visual acuity once in the 3-6 year old age range. These procedures should be conducted at the first visit during which the patient is cooperative.
    - The committee recommends testing visual acuity once in each of the following age ranges: 10-13, 14-18.

Developmental/Emotional/Behavioral Screening Tools Recommended for Use in EPSD&T

The following chart is a list of measures approved for use by EPSD&T. The Description column provides information on alternative ways (if available) to administer measures (e.g., waiting rooms). The Accuracy column shows the percentage of patients with and without problems identified correctly. The Time Frame/Costs column shows the costs of materials per visit along with the costs of professional time needed to administer each measure. For parent report tools, administration time reflects not only scoring of test results, but also the relationship between each test's reading level and the percentage of TNCare patients with less than a high school education (who may not be able to complete measures in waiting rooms due to literacy problems and will thus need interview administrations).

Measure	Age range	Description	Scoring	Accuracy	Time Frame /Costs[1]
Child Development Inventories (formerly Minnesota Child Development Inventories) (1992) Behavior Science Systems, Box 580274, Minneapolis, MN 55458 (phone: 612-929-6220)	3 - 72 months	60 yes-no description with separate forms for 0 – 18 months, 18 – 36 months and 3 – 6 years. Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation..	a single cutoff tied to 1.5 standard deviations below the mean	Sensitivity[2] was 75% or greater across studies and specificity[3] was 70%.	about 10 minutes (if interview needed) Materials ~40¢ Admin. ~$3.40 Total = ~$3.80
Parents' Evaluations of Developmental Status (PEDS). (1997) Ellsworth & Vandermeer Press, Ltd. 4405 Scenic Drive Nashville, Tennessee Phone: 615-386-0061; fax: 615-386-0346 http://edge.net/~evpress	ages birth to 8 years	10 questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Also in Spanish. Written at the 5th grade level. Normed in teaching hospitals and private practice..	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	sensitivity ranged from 74% to 79% and specificity ranged from 70% to 80%.	About 2 minutes (if interview needed) materials~31¢ admin. ~ $0.88 Total = $1.19
Brigance Screens.. Billerica, MA: Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA, 01862 (1-800-225-0248	21 - 90 months	seven separate forms, one for each 12 month age range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observation.	cutoff and age equivalent scores	sensitivity and specificity to giftedness and to developmental and academic problems was 70% to 82%	10 minutes (direct testing only) Materials ~53¢ Admin.~$10.15 Total = $10.68

EPSD& T Developmental/Behavioral/Emotional Screening tools (continued)

Pediatric Symptom Checklist. Jellinek MS, Murphy JM, Robinson J, et al. Pediatric Symptom Checklist: Screening school age children for psychosocial dysfunction. Journal of Pediatrics, 1988;112:201-209 (the test is included in the article and in the PEDS manual)	6 - 16 years.	35 short statements of problem behaviors to which parents respond with never, sometimes or often. The PSC screens for academic and emotional/behavioral difficulties.	single refer/nonrefer score	Sensitivity ranged from 80% to 95%. Specificity in all but one study was 70% to 100%	about 7 minutes (if interview needed) Materials ~ $.06 Admin. ~$2.38 Total = $2.44

TOOLS THAT ARE NOT RECOMMENDED BUT ARE ACCEPTABLE FOR AUDIT UNTIL 2003					
Denver-II	0 - 6	Combination of directly elicited, and interview, tapping language, personal-social, gross and fine motor, but not preacademic and academic skills	Pass/fail/ Questionable /untestable	Sensitivity 80%. Specificity 40% or sensitivity 40% and specificity 80%, depending on how the questionable score is handled.	15 minutes for younger children, 25 minutes for older children (combination of direct and interview items) Materials ~ $.31 Admin. ~$20.36 Total = $20.67
Informal checklists (such as those imbedded in age-specific encounter forms such as Bright Futures)	0 - 5	Usually tap different areas but lack scoring criteria, provide no proof that items tap important skills or predict developmental outcome.	none	Unknown but research shows that informal methods detect fewer than 30% of children with disabilities	Unknown but most have about 10 items and so may take about 2 minutes Materials ~ $.06 Admin.~$2.34 Total: $2.40

1. interpretation costs (i.e., the amount of professional time needed to explain results) are not included in the costs totals
2. Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test
3. Specificity = percentage of children without disabilities identified as probably normal by a screening test

Attachment D

EPSDT Pilot Study: Le Bonheur Children's Medical Center

EPSDT Pilot Study

Le Bonheur Children's Medical Center

Shelby County, Tennessee

July - September 1999

Submitted to the EPSDT Screening Guidelines Committee

Bureau of TennCare

Nashville, Tennessee

Executive Summary

The Consent Decree of the case of John B. v. Menke had specific implications for the screening of young children eligible for EPSDT via the State TennCare program. A Screening Guidelines Committee was a direct result of the negotiated agreement, and their charge was to develop recommendations for screening in the areas of child development, behavior, vision, and hearing. Prior to the formal presentation of recommendations to the TennCare Bureau, the Committee elected to implement a Pilot Study to assess the utility and effectiveness of the proposed guidelines.

The EPSDT Pilot Study was conducted by Le Bonheur Children's Medical Center via a grant from the State in two local pediatric practices in Shelby County, Tennessee. The objective was to pilot in clinical practice the subjective and objective recommendations offered to assess vision and hearing and the developmental and behavioral screening instruments proposed, which included the Parents' Evaluation of Developmental Status (PEDS), the Child Development Inventories (CDI), the Brigance Screens, and the Pediatric Symptom Checklist (PSC). The Pilot Study was completed in July and August of 1999. Prior to the clinical piloting of the recommendations, a Developmental Specialist and the Director of Developmental Pediatrics visited the practices and interviewed, oriented, and trained office physicians and staff. The Developmental Specialist also completed audits of sixty-eight (68) practice records with defined parameters to determine current practice.

A total of two hundred and nine (209) children were screened during the course of the Pilot Study, and the practices and the Developmental Specialist carefully documented screen selection and time requirements. Both practices had established practice patterns for vision and hearing that mostly satisfied the proposed recommendations. The results specific to the developmental and behavioral recommendations included a hesitant acceptance of the clinical application of the PEDS, the Infant Development Inventory (one of the CDI instruments), and the PSC in primary care settings. The remaining tools were less acceptable, because of either the time requirements associated with the screens, the cumbersome paperwork, practical office and family issues, or (specific to the Brigance) the impracticality of use in a primary care setting.

The most frequent opinion expressed pertaining to the screening recommendations was related to cost. There is cost associated with the screens themselves, clinical staff requirements, administrative tasks such as appropriate coding, and the general impact on the practice. There were also issues related to additional resource requirements (i.e. office staff), current reimbursement limitations, impact on access to care, training and education, and documentation. The clinical impression of the clarified screening recommendations was positive. However, most importantly, the introduction of additional requirements of providers will result in alarm and an increased demand for reconsideration of current reimbursement arrangements.

Introduction and History of the EPSDT Screening Guidelines Committee

The need for improved mechanisms of screening by TennCare providers can be attributed to multiple factors. Each of the following has recently influenced state-level discussions pertaining to screening performed by primary care providers.

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate within the federal Medicaid law- the program is intended to provide Medicaid-eligible children access to primary and preventive health care.
- Healthcare environment- Faced with unprecedented growth in health care costs, employers, state Medicaid programs, and other purchasers of healthcare have turned to managed care plans in an attempt to find effective strategies that provide access to quality health care while controlling costs.
- Consent Decree of the case of John B. v. Menke, - this case was a class action suit on behalf of all 500,000 TennCare-eligible children, up to age 21 alleging systematic failures to screen children according to the prescribed periodicity schedule, to properly diagnose their medical needs, and to provide them with the full range of health services they require.

Medicaid Managed Care News, 6/12/98

The Consent Decree committed the State to the full and effective implementation of EPSDT within the TennCare program. It has many major implications, a few of which directly address childhood screening. A brief synopsis of the language that specifically addresses childhood screening is as follows:

"Each TennCare child must receive four screens at least annually: medical, vision, hearing, and dental. Also prescribed in the decree is the development of uniform screening tools to be used to efficiently perform screenings. An expert panel of primary care providers and developmental and mental health experts (the EPSDT Screening Guidelines Committee) has been convened to develop a uniform screening tool for primary care providers to assist them in determining whether a child needs further diagnosis or treatment for mental health and developmental problems. The panel will also be developing hearing and vision screening recommendations." (Tennessee Justice Center)

The EPSDT Screening Guidelines Committee was formed in April 1998, as a result of the Consent Decree. The purpose was clearly to develop recommendations for screening. Recognizing advances in screening child development have been utilized in other arenas; the Committee's task was to offer recommendations to promote their practical use in primary care settings.

The recommendations developed for the State included prescribed hearing, vision, developmental and behavioral timelines and screening instruments for primary care providers to utilize during well child visits and for interperiodic screening. The Committee, however, recognized that the implementation of their recommendations should only be pursued following a trial period which allows for provider feedback related to the clinical impressions of the screening recommendations,feedback concerning resource requirements, communication of other concerns and difficulties encountered, and the general practicality of the recommendations. The State agreed to implement a pilot study to address these very issues.

EPSDT Pilot Study in Shelby County

As the recipient of the EPSDT Pilot Study grant form the State of Tennessee, Department of Health, Le Bonheur Children's Medical Center agreed to assess the utility and effectiveness of the hearing, vision, behavioral, and developmental screening guidelines proposed by the EPSDT Screening Guidelines Committee. The implementation of the study was tailored to address the committee's needs as defined by the group's drafted Scope of Services. The following objectives from the Scope of Services outlined the workplan adhered to and the findings for the Study.

1. Identify a pediatric practice to serve as the subject practice of the pilot study and provide training to members of the practice in the proposed screening guidelines.
2. Provide consultation and assistance to the members of the subject practices in implementing the proposed screening guidelines.
3. Conduct medical record reviews for the purpose of assessing the utility and effectiveness of the screening guidelines.
4. Survey the members of the practice on their perceptions regarding the utility and effectiveness of the proposed screening guidelines.
5. Provide a final report analyzing the utility and effectiveness of the proposed screening guidelines and offering recommendations for changes, if appropriate.

Protocol

It was established that "the purpose of the pilot study was to provide information on the use of the recommended screening procedures with TennCare patients in clinical practice sites". The recommendations consisted of acceptable subjective and objective screens and age appropriate recommendations to assess vision and hearing. The developmental/behavioral screens recommended included age appropriate use of the Parents' Evaluation of Developmental Status (PEDS), the Child Development Inventories (CDI), the Brigance Screens, and the Pediatric Symptom Checklist (PSC).

Two local pediatric practices were willing to pilot the Committee's recommendations. The practice-based course of the pilot consisted of two phases. Initially, the practices utilized ten of each of the developmental/behavioral screening recommendations (based on the child's age), with exception of the Brigance, randomly on children scheduled for a well-child visit each of four age ranges: Early Childhood (ages 0-2), *Pre*-School Age (ages 3-6) School Age (ages 7-12) and Adolescents (ages 13 and above). Following this phase (Phase One), a level of comfort with the instruments was established, and the sites randomly used the screens with approximately 15 children in each of the above mentioned age ranges. This was to satisfy the revision in the Pilot Study format to utilize the screens in Phase Two on 30 children in each of the four age ranges (15 per practice) instead of all children scheduled for a well child visit for a month period of time.

Each practice had a pre-established routine for screening vision and hearing that satisfied the criteria established by the Committee. Documentation of current practice for vision and hearing screening

and the use of the recommended developmental/behavioral instruments during both phases of the Pilot Study was formalized to assess the clinical efficacy of the Committee's recommendations.

Findings

Implementation of the Pilot Study was conducted during July and August of 1999, and the four primary objectives were completed. The findings of the Pilot Study are presented to share with the Committee both limited quantitative and more qualitative feedback related to their recommendations implemented in clinical practice. The findings are organized by objective and are reviewed in the following paragraphs.

- **Identification of a pediatric practice to serve as the subject practice(s) of the Pilot Study and provision of training to members of the practice on the proposed screening guidelines.**

Identification of the subject practices and training of the members of the practice on the proposed screening guidelines was completed shortly after the contract effective date. The two local practices recruited to work with Le Bonheur Children's Medical Center on the EPSDT Pilot Study are referred to as Practice A and Practice B. Similarly, each of these practices routinely cares for children enrolled in the TennCare program. Because of their size, location, and long-term presence in Shelby County, these practices are intimately familiar with the issues effecting EPSDT performance by community providers and were willing participants to pilot the committee's recommendations. The following table is a brief description of the characteristics of each practice:

	Practice A	Practice B
• **Volumes**	1500-2000/month	1300/month
• **Well Child Visits**	400/month	350-450/month
• **TennCare Percentage**	40%	70%
Providers:		
- Physicians	3/day	2 (at present)
- Clinical Staff	4 Nurses	1 PNP, 3 RN'S, 6 MA'S
- Office Staff	6	6.5

Initially, the Developmental Specialist and the Director of Developmental Pediatrics visited the practices, introduced the purpose of the study, and reviewed the tools and recommendations with the providers participating. Preliminary interviews were conducted to become familiar with current office practices for EPSDT screening and well-child care. The physicians also selected the office staff that would assist with the Pilot Study. Next, training on the screening recommendations and instructional review of the developmental and behavioral tools was conducted. Since the clinical staff performs the majority of the well-child exam, training for these practitioners was covered in greater detail.

- **Provide consultation and assistance to the members of the subject practices in implementing the proposed screening guidelines.**

As expected, the role of the Developmental Specialist was ongoing and continued well into Phase One; although, with time, the practices became more comfortable. Interestingly, current practice patterns markedly influenced the acceptance of screening tools as part of the routine well-child visits. In addition to initial and ongoing training and education in the practices, the Developmental Specialist worked closely with the identified office staff to familiarize them with the recommended screening tools. The Specialist modeled and assisted with the use of the developmental and behavioral instruments during Phase One (at Practice A), and primarily organized materials at Practice B. The Specialist was present when the practices completed most of the screens and was instrumental in documentation and analysis of resource requirements related to the screening recommendations. Her presence was invaluable in establishing a level of comfort in the practices with implementing the committee's recommendations.

- **Conduct medical record reviews for the purpose of assessing the utility and effectiveness of the screening guidelines.**

The third pilot objective was to audit practice records to determine current practice for EPSDT well-child visits. The developmental specialist conducted the chart audit of 48 records at each practice to establish a baseline. The initial audits reviewed 12 charts in each of the above mentioned four age groups for documentation related to any of the required EPSDT well-child visit screens, using the accepted parameters established by the screening guidelines committee. A second chart audit on twenty (20) charts was conducted at Practice A to document recent changes the practice had implemented to more comprehensively perform well-child exams. Audit results reflect documentation in the chart of an audit acceptable screen in the identified area and are summarized as follows:

	Hearing			**Vision**			**Developmental**				**Behavioral**		
	Subjective	Objective	Newborn Screen	Subjective	Objective	Unable to test	Informal	Denver	Identified	Milestones on form	Informal	Parent Report	Identified
Practice A: Total = 48	18	10	5	2	26	1	30				18	2	2
Practice A: Audit 2 Total = 20	1	10	5		10					19	9		
Practice B- Total =48	17	6		18	6		22	1	1		18		1

These results reveal that there were opportunities for improvement to adequately screen for all areas included under EPSDT. Because informal assessment was acceptable for audit purposes, the number of screens identified in the charts was close to half. There was also variability in how screening was performed and how screens were documented. Changes in current practice at each of the locations deserve mention as well. Practice A has introduced well child check-up forms within their charts, similar to the drafted preventative visit forms with the single exception being that their forms include developmental

milestones rather than utilized a separate screening instrument. The second record audit was a reflection of the recent introduction of the forms into practice. Currently, all well-child exams are completed with the new forms. At Practice B, this location has recently incorporated photoscreening into their well child exam routine.

Because of the change in the number of screens required during Phase Two, to thirty (30) per age group, it was difficult to audit one month's visits after Phase Two. After sharing this concern with the Committee, the conclusion was to share more qualitative feedback regarding the recommendations. Because of the changes in the Pilot Study structure, the primary benefit of the audit was the insight it offered about previous and current practice at each of the participating offices.

- **Survey the members of the practice on their perceptions regarding the utility and effectiveness of the proposed screening guidelines.**

Prior to and following the pilot, providers at each of the locations were surveyed about issues related to screenings, EPSDT, and TennCare. Pre-pilot interviews solicited physician and staff opinions pertaining to the study objectives and inadvertently fostered significant dialogue related to known TennCare strengths and shortcomings. Post-pilot feedback was gathered using the survey developed by the Screening Guidelines Committee and documentation of resource requirements tabulated from the Pilot Study. This activity solicited provider feedback regarding the pilot objectives, the screening tools, and the resource requirements associated with the Committee's recommendations. The issues introduced pre-pilot and post-pilot are consistent and are summarized later in this report.

- **Provide a final report analyzing he utility and effectiveness of the proposed screening guidelines and offering recommendations for changes, if appropriate.**

To fully detail the practical implications of the Committee's recommendations, the findings are organized into the following quantitative measurements and discussions sections. A total of two hundred and nine (209) children were screened during the course of the Pilot Study, and the practices and the developmental specialist carefully documented screen selections and time requirements for Phase One and Phase Two patients. The following tables quantitatively summarize the screen selections and time data collected for Phases One and Phase Two at Practices A and B.

Vision and Hearing Findings

As mentioned earlier, both practices had pre-established routine for screening vision and hearing. Therefore, compliance with the hearing and vision screening recommendations offered by the Committee was not difficult. Practice A used the eye chart for vision and the handheld audiometry for hearing. Practice B used the photoscreen for vision and both a whisper test (unacceptable practice) and audiometry (acceptable practice) for hearing. The amount of time required for these screens is noted in the following tables; however, the recommendations did not require any additional time of the sites, because these screens were already in place.

Pilot Study Phase One: Vision/Hearing Time Data		
	Practice A	Practice B
Vision	3 minutes	5 minutes
Hearing	1 minutes	1 minutes
Total Time	4 minutes	6 minutes

Pilot Study Phase Two: Vision/Hearing Time Data		
	Practice A	Practice B
Vision	3 minutes	4 minutes
Hearing	1 minutes	1 minutes
Total Time	4 minutes	5 minutes

Documentation for the Pilot Study may have required an additional step; however, in standard practice, clinicians should simply document these screens in the charts. Accepting both subjective and objective screens for vision and hearing compliments current practice. Also, establishing parameters for vision and hearing screens as defined by the Committee may assist providers to better document current practice or to introduce missing aspects of the EPSDT well-child exam. Subjective and objective alternatives also are considerate of practices that operate within tight financial limitations. An opportunity for improvement, that will be determined by future decision regarding newborn hearing screens, is to identify and address issues that hinder primary care providers receiving verification of newborns hearing screen results from birthing facilities for their assigned enrollees. Documentation of vision and hearing screens in the charts is an opportunity as well. Some practitioners routinely performed the screens as part of a well child visit but because of limited reimbursement potential, only documented in the chart the visit. In general, the vision and hearing recommendations did not unduly burden the practices participating in the study but do highlight opportunities for improvement in these areas.

Developmental and Behavioral Findings

During Phase One, there were thirty-six (36) children screened at each practice. The screen selection was random but using ten (10) of each of the recommended screens in each practice with the exception of the Brigance screens (Six (6) Brigance screens per practice were completed) for a total of seventy-two (72) children. During Phase Two, one hundred and thirty-seven (137) screens were performed using the preferred screening instruments but with a goal of thirty (30) children in total for each of the earlier mentioned age groups. Successful screening of this number of children in the younger age groups was accomplished, because many children in these age groups were in the office for school exams. Close to thirty (30) screens were performed in the 7-12 and 13 and above age groups; although during the time the study was completed, there were not quite enough scheduled well-child visits for children in these age ranges. The following table reflects the total number of children (Practice A and Practice B) by age screened during Phase Two.

Phase Two	Ages 0-2	Ages 3-6	Ages 7-12	Ages 13 and above	Total
Screens	34	51	29	23	137

The most frequent opinion expressed about the implementation of the developmental/behavioral screening recommendations in clinical practice pertained to its costs. The additional cost was directly associated with the additional time required of each exam. The providers also strongly expressed concerns with the cost associated with introducing these screens in their practices and given the already limited reimbursement for well child exams and primary care. Both locations are strongly opposed to introducing the screens within the current reimbursement fee structure. Practice staff are already overwhelmed with administrative responsibilities related to managed care, and the introduction of these screens would further impede available time for clinical practice. The amount of time required per screen was carefully documented throughout the pilot study. The following tables summarize the time requirements calculated for the developmental/behavioral screens in the participating practices.

Phase One- Practice A Time Data			
Screens	**Practice A Time**		**Number Completed**
PEDS	5 minutes		10
CDI	IDI	2.5 min.	5
	Early CD Inventory		
	PDI	8.5 min.	0 5
PSC	5.5 minutes		10
Brigance	20.5 minutes		6
Total Screens			36

Phase Two - Practice A Time Data					
Screens	**Ages 0-2**	**Ages 3-6**	**Ages 7-12**	**Ages 13 & up**	**Total By Screen**
PEDS	N=3 T= 4 minutes	N=13 T= 3.5 minutes	N=4 T=13 minutes	-	N=20
CDI	N=16 T= 2.5 minutes	N=11 T=10 minutes	-	-	N=27
PSC	-	N=1 T= 4 minutes	N=11 T=5 minutes	N=15 T=4.5 minutes	N=27
Brigance	-	-	-	-	-
Total By Age	19	25	15	15	

N= Number T= Time

Phase One - Practice B Time Data			
Screens	**Practice B Time**		**Number Completed**
PEDS	3.5 Minutes		10
CDI	IDI	3 min	5
	Early CD Inventory	3.5 min.	2
	PDI	8.5 min.	3
PSC	4.5 minutes		10
Brigance	20 minutes		6
Total Screens			36

Phase Two- Practice B Time Data					
Screens	**Ages 0-2**	**Ages 3-6**	**Ages 7-12**	**Ages 13 & up**	**Total By Screen**
PEDS	N=4 T= 3 minutes	N= 14 T= 4 minutes	N=1 T= 3 minutes	-	N= 19
CDI	N= 11 T= 3.5 minutes	N=11 T= 5.5 minutes	-	-	N= 22
PSC	-	N= 1 T=5 minutes	N= 13 T=4 minutes	N=8 T= 5.5 minutes	N=22
Brigance	-	-	-	-	-
Total By Age	N= 15	N= 26	N= 14	N= 8	

N= Number T= Time

The selection of the developmental and behavioral screens deserves mention. Although both locations appreciate the value of the Brigance instruments, they expressed tremendous concern about the appropriateness of its use in primary care settings. Concerns expressed were related to the time requirements to complete the screen and other office variables such as noise, parent/caregiver/sibling presence, space, cultural bias, and staff availability which influence the accuracy of the Brigance's findings in a primary care setting. Both practices completed six (6) Brigance screens each on young children (ages ranging from two to five) during Phase One but felt strongly that it was an obstacle to not only the efficient completion of the well-child exam but also to the daily routine of the practice. Acceptance of the remainder of the screen recommendation was cautious. The Infant Development Inventory (IDI), the Parent's Evaluation of Developmental Status (PEDS), and the Pediatric Symptom Checklist were the least cumbersome in the pilot settings. Even the Early Childhood Development Inventory and the Preschool Development Inventory could be lengthy and time-consuming. It was noted that parent questionnaires completed by provider interview elicited more information. Otherwise, some parent's simply mark short answers. As expected, parent interview was more time consuming. Providers recognized the significance in soliciting information from parents/caregivers that they otherwise may not generally offer. The screens

also highlight to the provider concerns that may require more specific follow-up. The practices identified concerns, however, related to other variables such as literacy, increased paperwork, differentiation of insurance providers, non-compliant families, and already identified conditions, delays, or disabilities. Equally as important as the outcomes specific to the pilot, the providers identified issues that can be generalized to the other providers across the state. The next section therefore incorporates these issues from the Pilot Study in the context of broader healthcare factors.

Discussion

In a recent position statement from the American Academy of Pediatrics (AAP), it is stated that the EPSDT benefit should include, as part of the well-child visit, developmental assessment, anticipatory guidance, vision and hearing testing, and behavioral assessment (RE9918). Several of these components mirror the foundation defined by the EPSDT Screening Guidelines Committee. These same components were the subject of the Pilot Study to evaluate the implications of uniform screening recommendations and to solicit practical considerations from the implementation of their recommendations in a clinical practice site.

In the literature, "a growing number of developmental specialists are urging pediatricians to use standardized parent questionnaires to detect developmental disabilities in children" (*Pediatric News*, August 1999). The same article says the AAP Committee on Children with Disabilities plans to highlight and endorse the use of parent completed tools in primary care settings. The change from the earlier endorsement is a result of research that validates the use of parent completed questionnaires in primary care settings. This acceptance was mirrored in the Pilot Study. The parent completed questionnaires in clinical practice provided useful clinical information to incorporate into the well-child exam. The tools were useful resources for providers and caregivers to increase awareness of developmental milestones and highlight opportunities for anticipatory guidance. The recommendations developed for vision and hearing screening were similarly well received. Both practices as part of the routine well-child exam performed screens of vision and hearing within the parameters developed by the Committee. The clinical value of clearly defined and validated expectations of primary care providers pertaining to the performance of screens for the well-child exam was therefore well received by the Pilot Study practices.

Feedback concerning resource requirements adds insight however to the practicality of additional specific expectations of primary care providers. The parent completed questionnaires required of the practices an additional three to five minutes per exam to complete. One provider expressed, "It may not seem like much but when you multiply it out across the board, it really adds up and puts everybody behind". Similarly, the vision and hearing screens require procedure time; however the participating practices already incorporated them into their practice routine.

Initially, it was difficult to incorporate the recommendations into the practices' routines although with time, their comfort levels improved. Each practice's on-site acceptance of the recommendations varied. The responses in actual practice ranged from acceptance and enthusiasm to skepticism and frustration. It was clear in these practices (and expected in practices across the State) that there is

variability in practice routine and approach to achieve EPSDT compliance. Both practices had implemented recent practice specific changes to more comprehensively fulfill EPSDT requirements. A consideration for the Committee is therefore to recognize ongoing efforts by some providers. The recommendation is to also include parameters for each domain defining acceptable practices for providers currently incorporating comprehensive screenings into their well child exam.

Other concerns worthy of note were related to training and education. Although the intent of the pilot was well understood, the training on each screening tool, the indicators for referral, and the documentation requirements were all opportunities for discussion during the Pilot Study. These responses of the practices highlight the importance of training and communication that should be addressed in the final recommendations.

"Successful early identification of developmental disabilities and delays requires the pediatrician (and other providers) to be skilled in the use of screening techniques and of developmental surveillance, to actively seek parental concerns about development, (behavior, vision and hearing), and to create linkages with resources in the community" (AAP, RE94140). Recommendations and resources to facilitate practice-based screening will be the cornerstone of more successful early identification. However, to be practical, the recommendations for EPSDT screening presented must also carefully balance qualitative benefit, impact on access, and economic implications.

Practices will gain experience with validated screening approaches and improve documentation for audits by managed care organizations (MCO's) and other third party payers. Practices with improved screening protocols will also introduce baselines for tracking children that may be at increased risk for developmental disability and/or delay, and for vision and hearing impairments. Improved screening mechanisms should facilitate improved access for children at risk or with identified developmental disability and delay, behavioral disorder, vision impairment, or hearing loss to diagnostic or rehabilitative resources.

However, the coordination of care including services rendered by specialists and other therapeutic providers for children identified will require more of the medical home provider. Inefficiencies related to the involvement of additional diagnosis, treatment and follow-up have in the past created barriers in communication with the primary care provider, resulted in inappropriate utilization of resources, and caused families and their children to be challenged by a poorly coordinated system. Improvements in access, therefore, also demand improvements in addition to the means of screening. Additional requirements of providers also risk interfering with access to primary care providers. The increase in the average length of a visit could decrease the number of visits per day. More cumbersome well-child exams could result in fewer scheduled per day; to allot for screening and the office visit, and hence reduce access in an already tightly scheduled practice.

Lastly, both practices, before and after the pilot, expressed issues with the cost of mandatory utilization of specific screens. Their concerns were related to the costs of the screens themselves and to the resource requirements of existing clinical and office staff in terms of preparation time, coding and

documentation, and practice efficiency. Their opposition stems from that the EPSDT requirements on States are part of a grossly underfunded Medicaid program. Providers already struggle with current mechanisms of reimbursement. Therefore, more than likely, the introduction of additional requirements of providers will result in an increased demand for reconsideration of current financial arrangements including reimbursement outside of the current capitation rates. The cost to providers will surface in terms of clinical staffing, supplies, and other administrative areas (i.e. office staff, coding and documentation, referrals, follow-up, etc).

The Pilot Study has been an opportunity for provider feedback to the EPSDT Screening Guidelines Committee. The clinical impressions of clarified screening recommendations has been positive. The practices, however, have true concerns about resource requirements, the communication of information, and practice support. Most importantly, the general practicality of the recommendations from their perspective is directly related the financial impact of the recommended changes and the adequacy of reimbursement mechanisms.

Attachment E

Summary of MCO Case Management Activities

SUMMARY OF MCO CASE MANAGEMENT ACTIVITIES

Case Management activities have grown and developed in all MCO's in 1998 and 1999. Some MCO's have extensive Case Management programs and other MCO's have programs that are evolving, as their Utilization Management processes become more sophisticated. Most Case Management programs have not been in place long enough to reflect any statistical data representing outcomes related to Case Management/ Disease Management programs.

STAFF EDUCATION/ORIENTATION

MCO's with continuing CM education/orientation include:
Xantus, Prudential, John Deere, Omni, Blue Cross, Access Med, Vanderbilt, and TLC.

MEMBER EDUCATION

MCO's with member education through newsletters &/or member handbooks include:
Xantus, Prudential, John Deere, Omni, Blue Cross, Access Med, Vanderbilt, and TLC.

INTERNAL CM PROGRAMS

MCO's with internal Case Management programs include:
Xantus, John Deere, Omni, Blue Cross, Access Med, Vanderbilt, and TLC.

DELEGATED CM PROGRAMS

MCO's that delegate their Case Management programs include Prudential who delegates to MedPartners, and PHP who delegates all UM activity to THP.

There were no noted deficiencies in case management activities from annual MCO surveys, however PHP had a recommendation that UR criteria for all delegate vendors be reviewed and approved on an annual basis. PHP delegated UM to THP on January 1,1999, and had a summary report from the audit findings. THP submitted a corrective action plan that was approved by PHP.

AREAS OF SPECIAL INTEREST

Case Managers at Blue Cross have authority to make referrals to specialists and authorize other resources and services without going through the PCP.

AccessMed conducts a Case Management Certification class for their staff

VHP expanded the Case management program to include a review of the Case Management Society of America (CMSA) standards.

Xantus has separate CM and DM Policy and Procedure Manuals.

Case managers at John Deere can make referrals using approved case management standing orders.

TLC has a community resource manual that lists self-help groups, mental health services, vision and hearing services, housing and day care services.

All MCO's measure their performance against predetermined benchmarks or are planning to do so.

Case Managers at most MCO's act as the MCO's contact with schools IEP, DCS, and state health departments.

Be. 11/8/99

EQRO summaries of individual CM activities are attached.

Attachment F

Revised Remedial Plan

DRAFT 8, 1/12/00

HEALTH PLAN FOR CHILDREN IN STATE CUSTODY

I. Principles

Children in state custody often have a greater incidence of physical, behavioral, and developmental problems. This is a plan for building a system that provides the services needed for these children and is guided by the following principles:

1. Complete EPSDT screening exams are needed on entrance into custody to allow for appropriate planning of any care that might be needed.
   - A. Screenings done by the primary care provider encompass physical, developmental, and behavioral health components using tools approved by EPSDT advisory committee.
   - B. Dental screenings will be arranged with dentists.
   - C. A more in-depth behavioral health screening should be done by a behavioral health provider unless adequate justification is documented that such a screening is not warranted.
2. Appropriate care should be provided as close to the place of residence as possible and build upon the patient's and family's strengths and needs.
3. Specialty and dental care should be available to meet all needs of these children.
4. Service coordination or case management is a critical component for any health system of children in custody – both while the child is in custody and during the phase of transitioning out of custody.
5. A health system for children in custody should be designed to allow for evaluation of the system as well as health outcomes of the children it serves.
6. The flow of health information within the system must allow for providers, DCS, and MCO's/BHO's to appropriately manage the care of children.
7. The system must include a sufficient array of services to assure that a child's needs are met on an individualized basis building upon the child's and family's strengths and, to the degree possible, furthers the goals of the permanency plan.
8. As the system is developed, Best Practice Network Providers will be created and Best Practice Guidelines will be established and followed.
9. Since behavioral health issues are prevalent in this group of children, an emphasis should be placed on this component of care.
10. Centers of Excellence for children's services should have a far greater appreciation for this population's health needs based on their medical expertise and role in the medical community at large.
11. The input of caregivers is needed to design a system for children in custody.
12. The needs of TennCare eligible children for health/behavioral health services should not influence custodial decisions.
13. All parties having a role in the provision of health/behavioral health services will act as an integrated, collaborative team collectively serving in the best

interest of the child, including but not limited to the network providers, COE, MCO, BHO, and DCS.

The TennCare Bureau, Department of Children's Services, tertiary pediatric centers, private physicians and mental health providers, Departments of Health and Mental Health propose a collaboration to develop, implement and maintain a system which will meet all the challenges and live up to the principles stated. It is the objective of this plan to have a comprehensive system of physical, behavioral and dental health services available to meet the needs of custody children by the end of Year 2.

II. DEFINITIONS

A. A "Center of Excellence" (COE) is a tertiary care center that possesses, or is in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors) and the unique health care needs of children in custody. (The five tertiary pediatric sites which currently are tertiary care centers for pediatrics and will be considered to perform functions of COE are in Johnson City, Knoxville, Chattanooga, Nashville, and Memphis. This does not preclude other sites being designated if later determined to be important to the system of care.)

B. The term "Best Practice Network" (BPN) refers to a group of providers (primary care, behavioral health, and dental) who have the interest, commitment, and competence to provide appropriate care for children in custody, in accordance with the terms of this Remedial Plan and statewide best practice guidelines.

C. The term "Children with Special Health Needs Panel" (CSHN Panel) refers to an entity comprised of those members identified in this Remedial Plan whose responsibility will be to advise concerning the development of a health service system for children in state custody.

D. The "Executive Oversight Committee" is composed of representatives from TennCare, Department of Children's Services, plaintiff's attorneys, defendant's attorneys, a representative from the Centers of Excellence, and an agreed-upon consultant. It will have primary oversight for the implementation of this plan.

E. Medically Necessary (definition in MCO and BHO contracts)

F. Screenings – the initial examination (physical, behavioral, and developmental) to determine if there are problems, or suspected problems.

G. Assessments – used in this document to mean an examination of a more diagnostic nature after a screening examination detects a real/suspected problem.

III. ESSENTIAL COMPONENTS OF HEALTH CARE SYSTEM

A. CENTERS OF EXCELLENCE

Pediatric tertiary care sites presently functioning in Tennessee will serve as Centers of Excellence (COE) for this health system. These sites already provide referral services for children and youth because

of the expertise they have for physical and developmental health problems of this age group. During the first year of operation the centers have agreed to accept the role outlined below. During this first year they are willing to explore additional functions or activities that might best be performed by them. Should the CSHN Panel recommend additional activities for the COE, and these are approved by the Executive Oversight Committee (see Steering and Monitoring), or should the Executive Oversight Committee recommend additional activities, then negotiations will occur for these to be done the second year by COE's.

Role of Centers of Excellence

The COE's will play different roles in care of custody children. For one group they will provide all, or the majority of, on-going care; for another group they will provide consults; and the remaining children in custody that have no direct contact with the COE's will benefit from their capacity, training, and quality assurance role for the system as a whole.

1. Recommend statewide best practice guidelines to CSHN Panel.
2. Provide training and in-service to Best Practice Network (BPN) and DCS providers and DCS staff.
3. Provide multidisciplinary evaluations, care plans and on-going care to children in custody when indicated.
4. Direct a system needs assessment inclusive of educational needs of providers, participating and non-participating providers, agencies providing services for children with special needs, availability of a continuum of services for children in custody, and other components as determined by the COE.
5. Assist DCS in developing protocols for direct referral to the COE, rather than a DCS Diagnostic and Evaluation Center, for certain exceptional cases.
6. Coordinate appointments for referrals and telephone consultations for specialized care for custody children, including notification of the BHO and MCO.
7. Provide follow-up contacts with caregivers, providers, and DCS to assure compliance with care plans of children seen at COE.
8. Provide consultations to BPN and DCS providers on special needs children (health and behavioral health).
9. Assist MCO's and BHO's in the recruitment of BPN providers by providing suggestions as well as names of providers willing to participate. It is understood the final responsibility for contracting for providers lies with the MCO's and BHO's.
10. Act as safety net provider for health and behavioral health needs of children in custody; assess the system to recommend strategies to strengthen the local health care system to decrease the need for the safety net function.

11. Participate in developing a quality assurance process for the system.
12. Determine when services are to be provided and reimbursed (by either MCO, BHO, or TennCare) if ordered by PCP or behavioral health provider but denied by the MCO or BHO.
13. Determine when specialist can serve as PCP on special cases where this is deemed in the child's best interest and the specialist is willing to accept this role. If an MCO already has a mechanism established allowing a DCS care manager to determine this, the COE does not have to be contacted.

B. BEST PRACTICE NETWORKS

There will be two categories in the BPN:

1. The primary care providers (PCP) who not only administer basic health care, but also coordinate all physical and behavioral care of each child assigned to them. They maintain all health records on each child they serve whether the care was provided by COE, another specialist in the BPN, or a behavioral health provider.
2. Specialty health, behavioral health and dental providers These providers will be recruited for the Best Practice Network to have easy access to services, but will not have the case management responsibility of the PCP.

While the PCP BPN is being developed, DCS will continue to use the providers who now serve their children. As the network is developed, DCS will arrange for screenings and care to be provided by BPN PCP's. The 95 county health departments will serve as a safety net for EPSDT screenings during the first year when these cannot be obtained through private providers, in or out of the BPN. The local health departments will be considered for PCP in BPN during the first year when other providers cannot be obtained and in the areas where primary care is available.

An adequate number of behavioral health professionals with appropriate expertise for custody children will be contracted by the BHO's to provide the behavioral health screenings and assessments as well as the medically necessary care that will be needed. It will be the rule rather than the exception, to screen all children coming into custody by behavioral health provider except those for whom there is adequate justification that a screening is not indicated (ex. young infant being adopted) as determined by the EPSDT exam of the PCP. Behavioral assessments will be conducted as clinically appropriate.

Role of the Primary Care Physician in Best Practice Network

1. Provide EPSDT screenings and make referrals for behavioral assessment (also document why a behavioral health assessment is not indicated on children for whom this is not ordered).
2. Provide primary care and coordinate all care including outpatient behavioral services.
3. Order referrals for dental and behavioral health screenings when indicated; refer to local physical and behavioral health professionals for specialty care; refer to COE's for specialty care when indicated; coordinate referrals with MCO/BHO.
4. Request telephone consultations from COE.
5. Communicate with caregivers on plan of care.
6. Maintain all health information on children assigned to them regardless of who provided the care (COE, local specialist, behavioral health provider); report to Health Unit of DCS any time health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care. (This will be done within the confines of the federal confidentiality laws. A protocol will be developed for the sharing of health information among the providers of this system.)
7. Forward pertinent information to providers seeing children on referrals.
8. Utilize (and document) best practice guidelines for care when developed and adopted by Panel and Executive Oversight Committee and document rationale for variation of best practice guidelines.
9. Review information provided by state or COE on caring for children in custody.
10. Participate in evaluation of system and outcomes with COE's, MCO's, BHO's, and Panel.
11. Participate in TennCare MCO's and BHO's serving their area.
12. Participate in COE provided training relative to behavioral health assessments and interventions.
13. For children with on-going care needs (who are not receiving direct care from COE and therefore, will not have a care plan developed by COE) develop a care plan and incorporate all the treatment needs of the child.

Incentives for recruitment of the PCP in the BPN will be: (1) a higher reimbursement rate for initial EPSDT exams; (2) a monthly case management fee in addition to what the MCO is paying the provider for the services; (3) training and in-service provided by COE; and (4) more efficient method for obtaining services from other providers for children. (When the PCP of a

BPN orders a referral and the MCO or BHO denies the service, the PCP can contact the COE for approval and the service will be provided and reimbursed.)

Role of the Behavioral Health Providers in Best Practice Network

1. Provide initial screening when referred by PCP; provide behavioral assessments when clinically indicated.
2. Provide behavioral health care when children are referred.
3. Forward information from screenings, assessments, or care to PCP in BPN; forward information to COE when requested; communicate information to BHO as requested to coordinate care.
4. Participate in developing best practice guidelines.
5. Utilize best practice guidelines when established and adopted by the system; document when a variation from the BPG is indicated.
6. Assist TennCare and BHO in evaluating the system and care.
7. Participate in TennCare and BHO as contracted provider.
8. Review information received from state and COE on how to best provide care for children in custody.
9. Participate in training provided by COE's for behavioral health assessments and interventions.
10. Coordinate care with BHO's in the form of eligibility checks, registration of care, and concurrent review/development of treatment plans when indicated.

Role of Other Providers in Best Practice Network

1. Dental providers will do screenings and provide care to children in custody; share health information with PCP; participate in TennCare MCO's in the area.
2. Medical specialists will provide assessments and care when referred by PCP; share health information with PCP; participate in TennCare MCO's in the area; follow best practice guidelines when developed; participate in evaluation of system and care of children.

TennCare is responsible for monitoring networks and enforcing standards for an adequate network according to contracts with MCO's and BHO's. The contracting of providers will be at the discretion of the managed care organizations.

C. MANAGED CARE AND BEHAVIORAL HEALTH ORGANIZATIONS

Since TennCare MCO's and BHO's are critical to the success of this health plan for children in custody, there will be one representative

from the MCO's and one from the BHO's included on the CSHN Panel.

Role of MCO's and BHO's

1. Participate on CSHN Panel through one MCO representative and one BHO who have appropriate expertise in pediatric health and behavioral health issues.
2. With TennCare Bureau develop the procedures for determining reimbursement when service was denied by MCO/BHO but approved by COE; when a covered service has been requested by a COE, or by a BPN provider with the concurrence of a COE, and the MCO/BHO does not believe the service is medically necessary, the MCO/BHO will be required to authorize the service. The MCO/BHO will then have the option of appealing to the state after the service has been delivered if the MCO/BHO believes the service was not medically necessary. If it is determined on appeal that the service was not medically necessary, the MCO/BHO will be reimbursed by the state for the cost of delivering the service.
3. Contract with BPN providers.
4. Develop procedures for assigning children in custody to BPN PCP's.
5. Assure that networks are adequate and meet the TennCare contract standards of access and availability; work collaboratively with Panel and COE's to recruit providers where needed.
6. Assist in developing best practice guidelines.
7. Continue to manage and be responsible for all aspects of the TennCare program (for MCO's) and TennCare Partners program (for BHO's) as specified in contracts with TennCare.

D. TENNCARE BUREAU (IN THE DEPARTMENT OF FINANCE AND ADMINISTRATION)

1. Provide direct reimbursement for initial EPSDT screenings (medical, dental, and behavioral).
2. Provide a per member/per month case management fee to PCP's in BPN for custody children.
3. Develop a process for reimbursement in "Reverse Medical Necessity" scenarios (When COE deems services to be indicated, they will be provided and the provider will be reimbursed. TennCare will determine the process for determining whether the MCO or BHO should pay for these services or TennCare.)

4. Continue reimbursement for physician case management and reverse medical necessity for 90 days on those children leaving state custody who have required on-going involvement of COE in care. (COE provided more than a clinical evaluation or consult. Multiple consults or visits were needed and continue to be needed during the transition period.)
5. Assure adequate network (as defined by contract) of physical, behavioral, and dental health providers with appropriate expertise for children in custody.
6. Contract with COE's to provide services negotiated for the mandates of this plan.
7. Fund a needs assessment for this health system for custody children.
8. Provide available encounter data to support the quality assurance and monitoring.
9. Provide resources for staffing CSHN Panel.
10. Participate on both the CSHN Panel and the Executive Oversight Committee.

E. DEPARTMENT OF CHILDREN'S SERVICES

1. Maintain responsibility of seeing that children in custody receive appropriate health services.
2. Provide care coordination as listed under F. CASE MANAGEMENT, DEPARTMENT OF CHILDREN'S SERVICES.
3. Provide a representative to CSHN Panel and Executive Oversight Committee.
4. For services provided by DCS, assure that these are utilized according to needs of individual children and not according to slots/placements available in the system.

F. CASE MANAGEMENT

1. DEPARTMENT OF CHILDREN'S SERVICES

Care coordination is now provided by DCS case managers while a child is in custody. The DCS health units assist them in making referrals and obtaining care for children.

The Role of DCS in Case Management

A. Assuring appointments are made for EPSDT and referrals for care.
B. Assuring assessment and care plans always get to PCP.
C. Assuring appropriate medical information always gets to provider who is doing consultation or specialty care.
D. Contacting COE for appointments or consults.
E. Supporting caregivers to see that the plan of care is implemented.
F. Coordinate with other child-service agencies in the community including working with school or child care staff when indicated for meeting needs of the plan of

care; DCS will attend school meetings when IEP is developed when possible and advocate for child; COE's will be consulted when a child is not progressing under the IEP and having educational problems.

G. Arranging for transfer of records from one PCP to another when a child is being transferred to another geographical area; records will be forwarded before transfer if possible but within a week otherwise.

H. Seeking consults (health unit nurse or psychologist) from COE when DCS feels the child is not making progress as expected, or is worsening, and the PCP refuses to consult or seek re-evaluation.

I. Arranging services for transitioning children out of custody; assuring targeted case management services for 90 days for children transitioning out of custody who have required on-going involvement of the COE in provision of care; providing up to 9 months of case management services after termination of state custody if requested by the COE.

J. Health care units will follow-up on any complaints that information concerning custody children is not getting to providers in a timely manner to provide appropriate evaluation and care.

K. DCS will develop re-entry measures specifying the number of children returning to custody, the reasons for return, and the length of time from termination of custody to re-entry.

L. When care plans are developed by Best Practice Network Providers or the Centers of Excellence, case managers will incorporate care plans in staffings held for the child, and will access services consistent with the needs identified in the care plan.

2. PRIMARY CARE PROVIDERS IN BEST PRACTICE NETWORK
The PCP is the real case manager in this network because this is the one provider that all children will have.

The role of the PCP in case management

A. Maintain all the health information on the children including behavioral health; (A protocol will be developed for the system to allow for sharing of information within the confines of the federal laws for confidentiality.)

B. Coordinate health services and be the case manager requesting assistance from DCS case manager in following up and assuring plan of care is implemented.

C. Consult with COE's when they need additional help in managing a case; coordinate these referrals with MCO/BHO.

The PCP must always be notified when a child is being transitioned out of custody (as well as the behavioral health provider if applicable) and requested to follow the child more closely. The PCP will notify DCS when he/she feels more intense case management (as defined by the consent decree and Medicaid regulations) is needed by DCS or DOH and this will be noted on the child's data record at DCS for tracking and evaluation purposes.

3. CENTERS OF EXCELLENCE

The PEDIATRIC COE's have significant expertise in children's medical and behavioral care, and will be utilized to develop care plans on the most complex cases of children in custody. Since they may be a great distance from the place of residence of the child, the PCP is in a better position to case manage and see that the care plan is implemented. Behavioral health treatment plans will be generated using the BHO approved format. BHO's will be involved in treatment plans when coordination of referrals and intense follow-up is required.

However, the COE will provide services which will facilitate following the children in custody.

The Role of the COE in Case Management

A. The care coordinator at COE is available for DCS to contact to arrange all the referrals as well as telephone consultations; this person also assures that information sent from DCS or PCP gets to the specialist seeing the child; that care plans developed by COE are sent to PCP and DCS.

B. Designated staff at COE will provide telephone follow-up to caregivers, DCS and PCP for care of certain children in need of intensive follow-up.

4. DEPARTMENT OF HEALTH

The department has existing programs designed to support children in school, follow children at risk of developmental delays and child abuse and neglect, assist children with chronic medical conditions access the services they need. When children are transitioning out of state custody and are at risk of being re-admitted to custody, when DCS requests assistance in following such children; DOH will provide care coordination and support service according to an agreed upon contract with TennCare for this targeted case management.

TRACKING

The tracking system is to allow evaluation of the system as well as assessing the quality of care of children. The major questions that a tracking system must answer are (a) *Are needs for custody children being identified? (b) Are services being delivered in a timely manner? (c) Are outcomes documented (including school performance where relevant)? (d) Are re-assessments made in a timely manner when progress is not made according to the care plan? (e) Are revisions of care plans made when progress is not made?* The Department of Children's Services has the TNKIDS data system designed and implemented in some areas of the state. This system is unique and could possibly contain all, or most, of the components needed to meet the two objectives. A group representing various entities of state government, the academic centers and individuals with expertise in program evaluation will review the system to determine:

1. If elements should be added to this system which will assist in evaluating services for children;
2. If additional information is needed for evaluation, and ways to retrieve this data;
3. Who can (feasibly and legally) have access to this system; and
4. What enhancements need to be made to meet the evaluation needs established by the CSHN Panel.

STEERING AND MONITORING COMPONENTS

1. A Children with Special Health Needs Panel will be appointed to advise on the development of the health system for children in custody.

The Role of the Children with Special Health Needs Panel

A. Develop a plan for building the best practice network.
B. Direct a needs assessment to determine the resources and gaps in services for children in custody; the educational needs of providers.
C. Determine components needed for monitoring and tracking system:
   - Review TNKids data base of DCS and C-Port of Tennessee Commission on Children and Youth; recommend modifications of these to enable monitoring of this remedial plan;
   - COE's will study the feasibility of developing an electronic tracking system which would contain all health information of custody children and could be monitored by COE's to determine the quality of the system as well as the progress and outcomes of individual children; CSHN's Panel will review any plan submitted by COE's and make a

recommendation regarding the feasibility and effectiveness.

- If the total electronic tracking system is not felt to be feasible, or if it is to be developed but will take more than one year, then the CSHN's Panel will recommend a methodology for determining:
  (1) If children not referred to COE's are getting appropriate care; and
  (2) are children referred to COE's getting appropriate care.

D. Adopt/develop recommended Best Practice Guidelines.

E. Adopt a process to assure quality in the system.

F. After assessing needs of system and progress made during Year 1, recommend to Executive Oversight Committee goals, objectives, and timelines for Year 2.

In order to complete these duties, there will be staffing provided for this Panel by the TennCare Bureau.

Members of the Panel will include:

- Commissioner of Health
- Commissioner of Mental Health/Mental Retardation or designee
- Representative of TennCare
- Representative of DCS
- Representative from each Center of Excellence
- Five practicing pediatricians – one from each catchment area of COE's
- Mental Health Professional
- Dentist recommended by Tennessee Dental Society
- MCO Medical Director and BHO representative with expertise in children's behavioral health issues
- Attorney for plaintiffs
- Attorney for defendants
- An appointment by plaintiff's attorneys who has expertise in children's health issues
- Foster parent

The members may wish to establish committees and ask various health professionals, representatives from various groups, or individuals with specific areas of expertise to work with a subcommittee to assess or plan on a particular component of the plan. These panel members may elect by 2/3's majority vote to add up to three members to the Panel.

Because behavioral health issues are prevalent and often severe in children who are in custody, the Panel will appoint a

Behavioral Health Subcommittee to address: BPN, protocols for Diagnostic and Evaluation Centers; Best Practice Guidelines; and innovative strategies for building behavioral health capacity in rural areas.

This panel will convene meetings as frequent as necessary to complete its task but will also maximize teleconferencing whenever possible.

2. Executive Oversight Committee
This committee will consist of:
- Representative from TennCare
- Representative from Department of Children's Services
- Commissioner of Health
- Plaintiffs' and Defendants' attorneys
- Consultant (agreed upon by State and Plaintiffs)
- One representative from COE's

This Executive Oversight Committee will have primary oversight for this health plan and will:

A. Monitor the progress of the Remedial Plan.
B. Negotiate any modifications to the Plan and the Agreement.
C. Review the recommendation from the CSHN Panel for Phase Two or Year 2; finalize Year 2 goals; objectives and timelines for the health plan.

SAFETY NET ISSUES

1. EPSDT ASSESSMENTS
   A. Physical health assessments – The local health departments will serve as safety net providers until the BPN is fully developed.
   B. Dental health assessments – Local health department will provide safety net where dental services are available; Out of network providers will be utilized if MCO has inadequate network. (TennCare will be notified to enforce standards regarding network adequacy.)
2. BEST PRACTICE NETWORK
   A. During phase one or the first year of operation, PCP providers for DCS will be utilized; as the BPN is developed, children will be assigned to these PCP's; during this phase if there is no BPN PCP, the local health departments with primary care capability will be considered for BPN PCP also.
   B. The Safety Net for any child who has severe, acute, or complicated problems (medical or behavioral) will be the COE's. A Behavioral Health Subcommittee will be

appointed by the CSHN Panel to address protocols used by DCS Diagnostic and Evaluation Centers; they will develop a system to assure that children with more complex and urgent behavioral problems get appropriate care and a continuum of care to meet their needs.

C. The Dental Safety Net will consist of the COE's with this capacity as well as out of network providers.

3. TENNCARE

A. Until all mechanisms for reverse medical necessity can be implemented, TennCare will designate their Medical Director as the contact when MCO/BHO's deny services which are felt to be urgently needed

Attachment G

TennCare Standard Operating Procedure 036 Addenda 2 and 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF TENNCARE
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

DATE: November 8, 1999

TO: TennCare MCOs & BHOs

TSOP: 036
Addendum 2

FROM: John F. Tighe
Deputy Commissioner
Department of Finance and Administration

SUBJECT: Coordination of EPSDT Services

Coordination between MCOs/BHOs and other children's health and education services and programs is essential to ensure and maximize children's health care services and to prevent duplication. Ideally, EPSDT services are part of a continuum of care. This TSOP has two purposes:

- to provide MCOs and BHOs with guidance and information about EPSDT resources available through other government agencies (see accompanying list); and
- to suggest strategies for ensuring coordination of EPSDT services among MCOs/BHOs and with other programs and services included in the accompanying list.

It is the Bureau's position that the use and coordination of services provided by other government agencies will result in several benefits to both the enrollees and MCOs/BHOs. The ultimate responsibility for providing EPSDT services to qualified enrollees is that of the MCOs and BHOs. This means that MCOs/BHOs cannot refuse to provide a necessary service because someone else should be providing it. The only reason for denying a requested service is because it lacks medical necessity. Among these benefits are:

- the containment of costs and improvement of services by reducing service overlaps or duplications and closing gaps in the availability of services;
- the ability to focus services on specific population groups or geographic areas in need of special attention; and
- a greater availability of needed services in a more localized area, reducing the amount of travel time and expense for the MCOs.

Coordination of effort includes the use of child health initiatives with other related programs, such as Head Start, the Special Supplemental Food Program for Women, Infants, and Children (WIC), school health programs of State and local education (including the Individuals with Disabilities Education Act of 1975). There is no single "list of approved roles", but other government agencies may provide a variety of outreach, screening, diagnostic or treatment services, health education and counseling, case management, facilities, and other assistance in achieving an effective child health program. MCOs may find it beneficial to establish active child health coordinating committees, with representation from providers, private voluntary and public agencies, which may be helpful in promoting cooperation in providing health services. The attachment to this TSOP is a statewide list of services for which EPSDT coordination is appropriate. The Bureau previously sent this list to MCOs and BHOs September 22, 1998.

In order to insure effective coordination with other agencies, TennCare suggests that formal or informal coordination agreements be developed as appropriate. Such agreements should contain the following elements:

- delineation of the mutual objectives and responsibilities of each party (i.e., MCO/BHO, local agency, and/or subcontractor);
- identification of the services each party offers and in what circumstances, including any restrictions;
- appraisal of the types of services provided by local agencies; and
- methods for:
    - early identification of individuals under 21 needing health services;
    - reciprocal referrals;
    - coordinating plans for health services provided or arranged for enrollees;
    - exchange of reports of services furnished;
    - continuous liaison between the parties; and
    - joint evaluation of policies that affect the cooperative work of the parties.

The overall goal is to improve the health status of children by assuring the provision of preventive services, health examinations, and the necessary treatment and follow-through care, preferably in the context of an ongoing provider-patient relationship and from comprehensive, continuing care providers.

Organization and Administration of EPSDT Programs

TennCare MCOs' and BHOs' provider networks should include providers who can deliver a broad array of services to children on a continuing basis. Other government programs can help in a number of ways such as:

- provision of outreach and referral services at the local level;
- utilization of Maternity and Infant Care and Children and Youth Projects, and other specialty and primary care programs as providers of comprehensive, continuing care;

- development of health services policies and standards and the assessment of quality of care issues including: implementation of professionally recognized protocols and standards of care; integration of services at local and regional levels with a view toward elimination of unnecessary services and duplication of services; providing acceptable quality of care; and
- integrating and providing all necessary services to this population.

TennCare, MCOs/BHOs, and government agencies working together have a major role in establishing standards, policies and procedures for health care services.

Coordination with:

- *Local Education Agencies (LEAs)*

  The development of linkages through the family to public, private, and community health and social agencies help link existing prevention and treatment programs with those services provided in the schools. Schools can be a focal point from which to identify children with problems, to increase student's access to both preventive and curative health services, and to assure appropriate use of health care resources. Coordinating services can avoid duplicating efforts that increase costs of services and adding further stress to the child and family. There is no single "best" way for schools to relate to EPSDT, since the populations, traditions, resources, and other factors vary greatly.

  The Bureau has already notified LEAs of the need to coordinate with MCOs and BHOs the needs of children that have been identified through the child's Individual Education Plan (IEPs). These plans are to be shared with the child's primary care physician. As an attachment to this TSOP is the release of information that the child's parent(s) is to sign giving permission to share this information.

- *The Head Start Program*

  Head Start shares the same child health and development goals as EPSDT. Approximately 50% of Head Start families are also TennCare families. Eligibility for the Head Start Program is based on income and family, similar to Medicaid criteria eligibility. There are additional criteria which gives an applicant "points" to qualify for Head Start.

- *The Special Supplemental Food Program for Women, Infant, and Children, Food and Nutrition Service, U.S. Department of Agriculture (WIC)*

  WIC provides specific nutritious supplemental food and nutrition education at no cost to low-income pregnant, postpartum, and breastfeeding women, infants, and children up to their 5th birthday. They must meet income guidelines, a State residency requirement, and be individually determined to be at "nutritional risk" by a health professional such as a physician, nutritionist, or nurse. WIC serves as an adjunct to good health care. Many TennCare families are WIC recipients.

Summary

EPSDT components are often part of a larger network of social service agencies and health programs for children. Coordination among these entities is crucial to ensure and improve access to services and to prevent duplication. Varying kinds of coordination and strategies are possible which can be used between MCOs/BHOs and other agencies. These collaborative efforts may include interagency agreements, cross-referrals, child-health coordinating committees, or other activities; the desired outcome shall be the stimulation of partnerships that ensure the improvement of the health and well being of children.

The Bureau of TennCare strongly recommends that MCOs and BHOs become familiar with the services provided by other government agencies and how they may benefit the enrollees through coordination of an enrollee's medical and mental health care, especially through EPSDT services. Identifying an individual(s) within your organization that could serve as the contact, or lead person, for EPSDT services can help to bring the various treatment plans together to provide the best service possible and work to eliminate duplicate services. This person should also be available to assist your customer relations representatives in resolving problems involving your enrollees. The Bureau will take the lead in urging other public and private agencies to designate a lead person to interface with the MCOs and BHOs in meeting the needs of the EPSDT population. Close working relationships will enhance the rapid identification of a child's problems and how to best meet those needs.

TennCare Authority:

U.S. Code Annotated Section 1396
Social Security Act Sections 1902(a)(43) & 1905(a)(4)(B);
Social Security Act Section 1905(r) as created by OBRA 89;
HCFA's State Medicaid Manual;
TennCare Rules and Regulation 1200-13-12-.04(1)(w) & 1200-13-12-.04(7);
TennCare/MCO Contract Section 2-3.a.1.;
TennCare/BHO Contract Section 2.6.1.

TennCare Contact Person:

Regarding -

Medical Issues:	Karen Oldham, M.D.	(615) 741-0213
Quality of Services -	Ken Okolo	(615) 741-0192
Policy -	Melvin Everette	(615) 741-0221
Contract Compliance -	Jack Welch	(615) 532-6743
EPSDT Coordinator -	Kasi Tiller	(615) 532-6089

do84d49308

enclosure

Statewide List of Services for Which EPSDT Coordination Is Appropriate

Bureau of TennCare
Tennessee Department of
Finance and Administration

Contents

Health Department Services

GENERAL EPSDT SERVICES PROVIDED
BY LOCAL HEALTH DEPARTMENTS:

Child Health: Well child checkups including physical examinations, screening tests and immunizations for children from birth to age 21. Referrals are made when necessary.

Immunizations: Various immunizations are available for children including: polio, diphtheria, whooping cough, tetanus, measles, mumps, rubella, hemophilius, and hepatitis B.

Primary Care: Primary Care services are available in some local health departments. Clinic staff are available to diagnose and treat acute and chronic illnesses and provide diagnostic testing, such as blood pressure screening and pap smears.

Family Planning: Patients can receive a complete physical examination and all appropriate laboratory tests. Education is provided about birth control and patients may be supplied with a birth control method.

Sexually Transmitted Disease Control: Confidential testing, treatment and partner notification is provided for sexually transmitted diseases, including HIV/AIDS.

Tuberculosis Control: Diagnosis, treatment, medication (when needed) and follow-up services for patients with tuberculosis and their contacts are provided.

Nutrition and Women, Infants and Children (WIC): Nutritionists and/or registered dietitians are available to counsel individuals with specific dietary needs. The WIC program issues vouchers for nutritious foods to women who are pregnant or breast feeding, as well as children under the age of 5 who are at risk of poor growth, if the families meet income guidelines. New mothers are also offered breastfeeding classes and support.

Children's Special Services (CSS): The CSS program assists with medical treatment for children until age 21, when the child has special medical needs and the family is unable to provide for necessary care. Speech and hearing services may also be provided under this program.

Prenatal: Pregnancy testing, presumptive eligibility screening for Medicaid/TennCare, and referral for prenatal care are available.

DEFINITIONS OF SERVICES PROVIDED BY HEALTH DEPARTMENTS
AS LISTED ON FOLLOWING CHARTS:

Child Health and Development Program (CHAD) is provided in 40 Tennessee counties, with target populations of pregnant women and children from birth to 6 years of age. Program goals are to prevent or reduce abuse, neglect, and developmental delays. Case Management Services are provided for the family and most visits are conducted in the home.

Clinical Dental indicates that the health department provides basic (diagnostic, preventive and restorative) dental care for indigent children, and emergency dental services (limited to diagnosis and treatment of an acute episode of pain, infection, swelling, hemorrhage or trauma) for indigent adults. Number of days listed on chart indicates how many days per week these services are provided.

Project HUG (Help Us Grow) is a program targeting families whose infants are considered to be at risk for medical or developmental problems. Home visits are made by a public health nurse, beginning during the prenatal period. Teen mothers and infants are given highest priority.

Full Prenatal indicates that the health department provides comprehensive prenatal care in accordance with ACOG standards. Number of days listed on chart indicates how many days per week these services are provided.

Basic Prenatal indicates that the health department performs pregnancy tests, enrolls the patient in WIC and signs the patient up for TennCare via presumptive eligibility. Number of days listed on chart indicates how many days per week these services are provided.

Primary Care PCP indicates that the health department has signed with MCO(s) to act as the primary care provider, providing 24-hour care and arranging referrals for these patients. The number of patients currently assigned to the respective health departments is listed. Number of days listed on chart indicates how many days per week these services are provided.

Primary Care Basic indicates that the health department is providing some acute care such as treatment for pharyngitis, otitis media, etc., but is not acting as the patient's PCP and does not provide 24-hour coverage. Number of days listed on chart indicates how many days per week these services are provided.

COUNTY	CHAD	CLINICAL DENTAL	HOME HEALTH	HUG	PRENATAL CARE Full	PRENATAL CARE Basic	PRIMARY CARE PCP	PRIMARY CARE Basic
Carter	x	2 days		x		x		
Greene	x	5 days		x		x		4.5 days
Hancock	x		x	x		x		
Hawkins	x	3 days	x	x		x		5 days
Johnson	x	2 days		x		x		
Unicoi	x	2 days		x		x		
Washington	x	5 days		x		x		5 days

NORTHEAST TENNESSEE

COUNTY	CHAD	CLINICAL DENTAL	HOME HEALTH	HUG	PRENATAL CARE Full	PRENATAL CARE Basic	PRIMARY CARE PCP	PRIMARY CARE Basic
Anderson	x	4 days		x	x	x		
Blount	x			x		x		
Campbell	x	1 day		x		x		5 days
Claiborne	x			x		x		
Cocke	x	1 day		x		x		
Grainger	x			x		x		
Hamblen	x			x		x		
Jefferson	x			x		x		
Loudon	x			x		x		
Monroe	x	4 days		x		x		
Morgan	x			x		x		
Roane	x			x		x		
Scott	x			x		x		
Sevier	x			x		x		
Union	x			x		x		

EAST TENNESSEE

COUNTY	CHAD	CLINICAL DENTAL	HOME HEALTH	HUG	PRENATAL CARE Full	PRENATAL CARE Basic	PRIMARY CARE PCP	PRIMARY CARE Basic
Bledsoe		potential for 20 hrs. week no provider		x		x		
Bradley		3 days	x	x	0.5 days	x		5 days
Franklin				x		x		
Grundy				x		x		
McMinn		5 days		x		x		2 days
Marion		2.5 days		x		x		
Meigs				x		x		
Polk				x		x		
Rhea		potential for 20 hrs. week no provider		x		x		
Sequatchie				x		x		

SOUTHEAST TENNESSEE

COUNTY	CHAD	CLINICAL DENTAL	HOME HEALTH	HUG	PRENATAL CARE Full	PRENATAL CARE Basic	PRIMARY CARE PCP	PRIMARY CARE Basic
Cannon	x			x		x		0.5 days
Clay	x			x		x	15 patients	5 days
Cumberland	x	3 days		x		x	1577 patients	5 days
Dekalb	x	2 days		x		x		0.5 days
Fentress	x			x		x		0.5 days
Jackson	x	1 day		x		x	14 patients	5 days
Macon	x	1 day		x		x	40 patients	4 days
Overton	x			x		x		1.5 days
Pickett	x	2 days		x		x		0.5 day
Putnam	x	5 days		x		x	1250 patients	5 days
Van Buren	x	1 day		x		x		0.5 day
Warren	x	3 days		x		x		1 day
White	x	1.5 days		x		x		0.5 day

COUNTY	CHAD	CLINICAL DENTAL	HOME HEALTH	HUG	PRENATAL CARE Full	PRENATAL CARE Basic	PRIMARY CARE PCP	PRIMARY CARE Basic
Cheatham				x		x		
Dickson		3 days		x	x		755	
Houston				x		x		
Humphreys				x		x		
Montgomery				x		x	961	
Robertson				x		x		
Rutherford		5 days		x	x		612	
Stewart				x		x	477	
Sumner		5 days		x		x	858	
Trousdale				x		x		
Williamson				x		x	1021	
Wilson				x		x	430	

MID-CUMBERLAND

COUNTY	CHAD	CLINICAL DENTAL	HOME HEALTH	HUG	PRENATAL CARE Full	PRENATAL CARE Basic	PRIMARY CARE PCP	PRIMARY CARE Basic
Bedford				x	x		578	
Coffee				x		x		
Giles				x		x	539	
Hickman				x		x		
Lawrence				x		x		
Lewis				x		x		
Lincoln				x		x		
Marshall				x		x		
Maury				x		x	925	
Moore				x		x	152	
Perry				x		x		
Wayne				x		x		

SOUTH CENTRAL

Mental Health Services

Community Mental Health Centers:
A special feature of the TennCare Partners Program is the emphasis on community support services that are offered primarily through Community Mental Health Agencies and Case Management Agencies. Tennessee is moving away from the "institutional" model of delivering mental health care toward a more normalized model. Support services are now offered to individuals to help them remain in their homes and communities. The particular configuration of services that they receive will be planned and delivered in such a way as to produce reductions in their unwanted symptoms and improvements in their overall quality of life.

Services offered by these community providers include: outpatient mental health services; pharmacy and laboratory services; outpatient substance abuse services; crisis services and transportation. Additional services for people with Severe and/or Persistent Mental Illness (SPMI) or Serious Emotional Disturbance (SED) include mental health case management, residential treatment services, housing supports, psychosocial rehabilitation, and specialized outpatient services.

Tennessee Community Mental Health Centers:

Carey Counseling Center
408 Virginia Street
Paris, TN 38242 901/642-0521

Centerstone Community Mental Health Centers
1101 6th Avenue North
Nashville, TN 37204 615/480-4000

Cherokee Health Systems
6350 West Andrew Johnson Highway
Talbott, TN 37877 423/586-5031

Cumberland Mental Health Services
1404 Winter Drive
Lebanon, TN 37087 615/444-4300

Elam Mental Health Center
1005 D.B. Todd Boulevard
Nashville, TN 37208 615/327-6609

Fortwood Center
1028 East 3rd Street
Chattanooga, TN 37403 423/266-6751

Frayser Family Counseling Center
2150 Whitney Avenue
Memphis, TN 38127 901/353-5440

Frontier Health
109 West Watauga Avenue
Johnson City, TN 37605 423/232-4323

Helen Ross McNabb Canter
1520 Cherokee Trail
Knoxville, TN 37920 423/637-9711

Midtown Mental Health Center
427 Linden Avenue
Memphis, TN 38128 901/577-9450

Overlook Center
3001 Lake Brook Boulevard
Knoxville, TN 37909 423/588-9938

Professional Counseling Services
1997 Highway 51 South
Covington, TN 38019 901/476-8967

Quinco Community Mental Health Center
Route 1, Box 500, Highway 64 West
Bolivar, TN 38008 901/658-6113

Ridgeview Psychiatric Hospital and Center
240 West Tyrone Road
Oak Ridge, TN 37830 423/482-1076

Southwest Mental Health Center
3810 Winchester Road
Memphis, TN 38181 901/369-1420

The Guidance Center
118 North Church Street
Murfreesboro, TN 37133 615/893-0770

Vanderbilt Community Mental Health Center
Vanderbilt University Medical Center
Department of Psychiatry
2100 Pierce, Suite 118
Nashville, TN 37232 615/343-7123

Volunteer Behavioral Health Care System
Moccasin Bend Road
Chattanooga, TN 37405 423/756-0755

Whitehaven-Southwest Mental Health Center
1087 Alice Avenue
Memphis, TN 38106 901/774-7911

Mental Retardation and Developmental Disability Services

Mental Retardation and Developmental Disabilities Centers:

Regional Mental Health and Mental Retardation Offices:
Community based services are provided by private, not-for-profit and for-profit agencies that contract with the State. Programs are designed to help people maximize their potential in the most integrated setting possible. Services include adult day training, vocational programs, supported employment, community participation, early intervention services for preschoolers, residential and supported living services, family support services, and a variety of support services.

Three regional offices coordinate services for persons with mental retardation:

East Tennessee Regional Office
5908 Lyons View Pike, Greenbriar Cottage
Knoxville, TN 37919 423/588-0508

Middle Tennessee Regional Office
275 Stewart's Ferry Pike
Nashville, TN 37214 615/231-5078

West Tennessee Regional Office
275 Martin Luther King Drive
Jackson, TN 38301 901/426-0675
(Memphis #: 901/685-3918)

Developmental Disabilities Centers:
Three state-operated developmental centers provide residential care for persons who have profound or severe mental retardation, usually with multiple handicaps. Individuals residing in developmental centers require 24-hour care in a highly supervised setting.

There are three state-operated developmental centers in Tennessee:

Arlington Developmental Center
P.O. Box 586
Arlington, TN 38002 901/745-7200

Clover Bottom Developmental Center
275 Stewart's Ferry Pike
Nashville, TN 37214 615/231-5000

Greene Valley Developmental Center
P.O. Box 910
Greeneville, TN 37744 423/787-6800

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
CORDELL HULL BUILDING, 5TH FLOOR
425 FIFTH AVENUE, NORTH
NASHVILLE, TENNESSEE 37243

MENTAL RETARDATION COMMUNITY SERVICES

CONTRACTED AGENCIES

TYPES OF SERVICES PROVIDED

AD	Adult Day Services
DD	Developmental Disabilities
D & E	Diagnosis and Evaluation
EI	Early Intervention Services
EI-H	Early Intervention Services- Part H
FS	Family Support
ISC	Independent Support Coordination
MW	Medicaid Waiver
MWAD	Medicaid Waiver Adult Day Program
MWRES	Medicaid Waiver Residential Program
RC	Respite Care
RESA	Community Residential Program for Adults
RESC	Community Residential Program for Children
SL	Supported Living
SS	Supportive Services
ST	Statewide

This is not a complete listing of providers of services to persons with mental retardation in Tennessee. This list includes only those agencies with which the Tennessee Department of Mental Health and Mental Retardation contracts for services.

September 10, 1998

EAST TENNESSEE

FUNDED SERVICES

Adult Community Training, Inc.
P.O. Box 276
Lenoir City,Tennessee 37771
Phone: (423) 988-9494 Fax: (423) 986-1137
Director: Bill Reynolds E-Mail: Int.adult3@conc.tds.net
Chairperson: Dr. Walter Shea

AD
MWAD
MWRES
RESA
SL

Arm's Reach
821 East Tri County Boulevard
Suite E
Oliver Springs, Tennessee 37840
Phone: (423) 435-9385 Fax: (423) 435-9387
Director: Jean Loebbaka
President: Jane Durbin

ISC

Arc of Claibome County
(Cumberland Mountain Industries)
P. O. Box 538
Tazewell, Tennessee 37879
Phone: (423) 626-6757 Fax: (423) 626-1088
Director: Scott Ferguson
Chairperson: Darrell Allen

AD
EI-H
FS
MWAD
MWRES

Arc of Hamilton County
109 North Germantown Road
Chattanooga, Tennessee 37411
Phone: (423) 624-6887 Fax: (423) 698-8520
Director: Mike Brewer
Chairperson: Richard E. Burke

ISC
RC

Arc of Washington County
2700 South Roan Street, Suite 105
Johnson City, Tennessee 37604
Phone: (423) 928-9362 Fax: (423) 928-7431
Director: Bill Schiers
Chairperson: Mary Jordan

FS
EI-H
ISC
RC
SC

Beta Home
1809 Luttrell Street
P. O. Box 185
Knoxville, Tennessee 37901-0185
Phone: (423) 523-2135 or 523-7683 Fax: (423) 673-5863
Director: Jennifer Beatty
Chairperson: Mark Medley

MWRES
RESA

Bradley/Cleveland Developmental Services, Inc.
P. O. Box 29
Cleveland, Tennessee 37364
Phone: (423) 472-5268 or 479-8704 Fax: (423) 472-5268, ext. 47
Director: Walter Hunt
Chairperson: Dr. Raymond Brown

AD
MWAD
MWRES
RESA
SL

EAST TENNESSEE

FUNDED SERVICES

Carter County Community Residence
802 Sixth Street
Elizabethton, Tennessee 37643
Phone: (423) 542-3649 or 753-8255 Fax: (423) 753-7062
Director: Pat Little Williams
Chairperson: Sam LaPorte

RESA
MWRES

Cerebral Palsy Center for Handicapped Adults, Inc.
241 Woodland Avenue, NE
Knoxville, Tennessee 37917
Phone: (423) 523-0491 Fax: (423) 523-0492
Director: Robert (Bob) Sexton
Chairperson: Steve Early

AD
FS
MWAD
MWRES
SL

Comcare, Inc.
P.O. Box 1885 (705 West Main, Zip: 37743)
Greeneville, Tennessee 37744-1885
Phone: (423) 638-3926 Fax: (423) 638-1105
Director: John Johnson, Ph. D.
Chairperson: Lynn Hankins

AD
MWAD
MWRES
SS
SL

Community Network Services
109 Northshore Drive, Suite 215
Knoxville, Tennessee 37919
Phone: (423) 588-3449 Fax: (423) 588-3644
Director: Donna Harris
Chairperson: John Harris

ISC

Comprehensive Family Services (CFS)
7514 Sutton Road
Ooltewah, Tennessee 37363
Phone: (423) 344-1586 Fax: (423) 344-5525
Director: James L. Stubbs
Chairperson: Michael Cox

AD
MWRES

Dawn of Hope Developmental Center, Inc.
1500 East Millard Street
Johnson City, Tennessee 37601-3545
Phone: (423) 434-5600 Fax: (423) 434-5629
Director: Lee Chase
Chairperson: Jack Shaver

AD
MWAD
MWRES

Douglas Cooperative
1101 Wagner Drive
Sevierville, Tennessee 37862-3719
Phone: (423) 453-3254 Fax: (423) 453-3105
Director: Paula York
Chairperson: John Richardson

AD
EI
MWAD
MWRES
RESA

EAST TENNESSEE

FUNDED SERVICES

Emory Valley Center, Inc.
715 Emory Valley Road
Oak Ridge, Tennessee 37830
Phone: (423) 483-4386 Fax: (423) 482-5435
Director: Allen Hendry
Chairperson: Susan Fallon

AD
EI
FS
MWAD
MWRES
RESA
SL

Evergreen Presbyterian Ministries, Inc.
P.O. Box 31746
Knoxville, TN 37930-1746
Phone: (423) 531-9118 Fax: (423) 531-9149
Acting Director: Mary Mills
Chairperson: Curtis Lackey
President/CEO: Bernard Wagner, Ph.D.

MWAD
RESA

Exceptional Enterprises, Inc.
HCR 77 Box 9
Coalmont, Tennessee 37313
Phone: (931) 692-2235 Fax: (931) 692-2244
Director: Bill Lingle
Chairperson: Mr. Henry Crais

AD
MWAD
MWRES
SL

Frontier Health
109 W. Watauga Avenue
P. O. Box 2226
Johnson City, Tennessee 37605
Phone: (423) 232-4380 Fax: (423) 232-4393
Director: E. Douglas Varney
Chairperson: Helen Whitson

AD
EI-H
FS
MWAD
MWRES
RESA
SL

Gateway House, Inc.
Rt. #1, Holston College Road
P. O. Box 220
Louisville, Tennessee 37777
Phone: (423) 984-9873 Fax: (423) 984-9873
Director: Dianna Culbertson
Chairperson: Dr. Roberta Werner

RESC

Goodwill Industries
5508 Kingston Pike
P. O. Box 11066
Knoxville, Tennessee 37939-1066
Phone: (423) 588-8567 Fax: (423) 588-0075
Director: Robert Rosenbaum, Ed.D.
Chairperson: Hugh Bright

AD

Greene County Skills, Inc.
490 Sunnyside Road
Greeneville, Tennessee 37743
Phone: (423) 639-5351 Fax: (423) 639-6048
Director: Jim Gillen
Chairperson: Harold Love

AD
FS
MWAD
MWRES
SL

EAST TENNESSEE

FUNDED SERVICES

Grundy County Department of Education — EI
P. O. Box 97, Highway 108/56
Altamont, Tennessee 37301
Phone: (615) 692-3467 Fax: (615) 692-2188
Director: Jennifer Thomas
Chairperson: Leon Woodlee

Chip Hale Center (Helping Hands of Hawkins Co.) — AD, MWAD
310 Hasson Street
Rogersville, Tennessee 37857
Phone: (423) 272-3966 Fax: (423) 272-4025
Director: Tony Cradic
Chairperson: Joe Drinnon

Independent Opportunities of Tennessee — AD
9040 Executive Park Drive, Suite 244
Knoxville, Tennessee 37933
Phone: (423) 531-9155 Fax: (423) 531-9149
Director: Melissa Morelli
Chairperson:

Knox County Association for Retarded Citizens — AD, DD, EI, SL
P. O. Box 2041, 3000 North Central
Knoxville, Tennessee 37901
Phone: (423) 546-9431 Fax: (423) 546-7960
Director: Vicki Johnson, Ph.D.
Chairperson: Fred Jones

Lakeway Center, Inc. — AD, MWAD, MWRES, RESA
320 Industrial Avenue
Morristown, Tennessee 37813
Phone: (423) 586-0701 Fax: (423) 586-9958
Director: Bruce Ingle
Chairperson: Charles R. Metz

Laughlin Hospital, Inc. (Infant/Toddler Intervention Project) — EI
1420 Tusculum Boulevard
Greeneville, Tennessee 37745
Phone: (423) 787-5097 Fax: (423) 787-5083
Director: Noah Roark
Chairperson: C. Ray Adams, CPA

Little Tennessee Valley Educational Cooperative — EI, EI-H
1432 East Lee Highway
Loudon, Tennessee 37774
Phone: (423) 458-8900 Fax: (423) 458-8626
Director: Jerome (Jerry) H. Morton, Ph.D.
Chairperson: Mary Hendershot

EAST TENNESSEE	FUNDED SERVICES
Michael Dunn Center P. O. Box 507, Rt. #3, Gallaher Road Kingston, Tennessee 37763 Phone: (423) 376-3416 Fax: (423) 376-3532 Director: Kyle Hauth E-Mail: Int.khauth@hotmail.com Chairperson: Dr. Clyde Cobb, President	AD EI MWAD MWRES RESA SL
Morristown/Hamblen Day Care Centers, Inc. P. O. Box 1936 Morristown, Tennessee 37816-1936 Phone: (423) 587-3001 Fax: (423) 587-6779 Director: Judy Brasher Chairperson: Jim Wills	EI
National Mentor Healthcare, Inc. dba Tennessee Mentor 6025 Brookvale Lane, Suite 110 Knoxville, TN 37919 Phone: (423) 584-1388 Fax: (423) 584-3313 Director: David Hamilton Chairperson: Gregory Torres, President	MWRES
Omni Vision (*Serving East, Middle and West Tennessee* Omni Community Services 101 Lea Avenue Nashville, TN 37210 Phone: (615) 726-3603 Fax: (615) 726-0393 Director: Julia Bratcher (MHMR Services) Chairperson: Charles McLeroy	MWRES
Orange Grove Center 615 Derby Street P.O. Box 3249 Chattanooga, Tennessee 37404-0249 Phone: (423) 629-1451 Fax: (423) 624-1294 Director: Mike Cook Chairperson: Thomas H. Cox	AD MWAD MWRES RESA SL
Rebound, Inc. 3111 Ramona Avenue Knoxville, Tennessee 37921 Phone: (423) 633-5900 Fax: (423) 633-5900 (call first) Director: Jim Warchol	MWAD
Regional Education and Community Health Services (REACHS) 507 Main Street P. O. Box 209 Jacksboro, Tennessee 37757-0209 Phone: (423) 562-1156 Fax: (423) 566-5106 Director: Cindy Nance Chairperson: William R. Pratt	AD MWAD MWRES

EAST TENNESSEE	FUNDED SERVICES
Rhea of Sunshine, Inc. 400 Greenway Blvd. Dayton, Tennessee 37321-9249 Phone: (423) 775-4855 Fax: (423) 775-4083 Director: Terry Wilkey Chairperson: Mary Travis	AD MWAD MWRES
Scott Appalachian Industries, Inc. 591 East Montecello Pike Huntsville, Tennessee 37756 Phone: (423) 663-2878 Fax: (423) 663-3365 Director: Larry West Chairperson: Martin Shoemaker	AD SL
Sertoma Center, Inc. 1400 East Fifth Avenue Knoxville, Tennessee 37917 Phone: (423) 524-5555 Fax: (423) 524-5563 Acting Director: Sandy Cooper Chairperson: Sarah Swanson Higgins	AD DD MWAD MWRESA RESA RESC SL
Signal Centers, Inc. 109 North Germantown Road Chattanooga, Tennessee 37411-2790 Phone: (423) 698-8528 Fax: (423) 698-8520 Director: Linda McReynolds Chairperson: Joe Schmissrauter, III	AD EI EI-H
Siskin Memorial Foundation, Inc. 1 Siskin Plaza, P.O. Box 365 Chattanooga, Tennessee 37401-0365 Phone: (423) 634-1760 Fax: (423) 634-1717 Director: Shawn Kurrelmeier Chairperson: Tom Kale	EI
Sunrise United Cerebral Palsy of East TN 9050 Executive Park Drive Suite C-115 Knoxville, Tennessee 37923 Phone: (423) 690-9070 Fax: (423) 690-6221 Director: Yolanda Pena Chairperson: Les W. Leech, Jr.	MWRES
T.A.P., Inc. (The Alternative Program, Inc.) 207 National Drive, Apt. 97 Murfreesboro, Tennessee 37128 Phone: (615) 907-0305 Fax: (615) 907-0306 Director: Scot Booth Director of Operations: Kim Hancock Chairperson: John Schukle	ISC

EAST TENNESSEE — FUNDED SERVICES

T.E.A.M. (Community Connections) — ISC
The Professional & Developmental Team Building
600 North Holtzclaw Avenue, Suite 100
Chattanooga, Tennessee 37404-1220
Phone: (423) 622-0500 Fax: (423) 622-0564
Director: Carol Burhenn
Chairperson: Dale Engstrom

Team Evaluation Center — D & E
The Professional & Developmental Team Building — FS
600 North Holtzclaw Avenue, Suite 100 — SS
Chattanooga, Tennessee 37404-1220
Phone: (423) 622-0500 Fax: (423) 622-0564
Director: Alan Bullard
Chairperson: Father James Marquis

Tennessee Mentor (see National Mentor Healthcare, Inc.)

Tri-County Center — AD
3030 Lee Highway, Northridge Industrial Park — MWAD
P. O. Box 793 — MWRES
Athens, Tennessee 37371-0793 — RESA
Phone: (423) 745-8902 Fax: (423) 745-2840 — SL
Interim Director: Lena Webb
Chairperson: Robert (Bob) James Granger

U. T. Developmental & Genetic Center — DD
1930 Alcoa Hwy., Suite 435 — D&E
Knoxville, Tennessee 37920-1514 — ISC
Phone: (423) 544-9030 Fax: (423) 544-6675 — EI
Director: Dr. Carmen Lozzio
ISC Contact: Mr. Bill Shelton
Chairperson:

U. T. Pediatric Language Clinic — EI
909 Mountcastle Drive — EI-H
Knoxville, Tennessee 37996
Phone: (423) 974-6702 Fax: (423) 974-1539
Director: Pat H. Webb, M.Ed.
Chairperson:

Vision Coordination Services, Inc. — ISC
515 Airport Road, Suite 113
Chattanooga, TN 37421
Phone: (901) 637-5348 Fax:
Director: Cedric Deadmon
Office Contacts: Becky Roberts, pager - (423) 819-0365
Nicole Breard, pager - (423) 819-0529

EAST TENNESSEE

FUNDED SERVICES

Washington County Community Residential Services, Inc.
802 Buffalo Street, Suite 8
Johnson City, Tennessee 37604
Phone: (423) 928-2752 Fax: (423) 928-3680
Director: Ron Bennett
Chairperson: Janie H. Snyder

AD
MWRES
RESA
SL

MIDDLE TENNESSEE

FUNDED SERVICES

Arc of Davidson County
1207-17th Avenue South, Suite 100
Nashville, Tennessee 37212
Phone: (615) 321-5699 Fax: (615) 322-9184
Director: Norm Tenenbaum
Chairperson: Elise McMillan

FS
ISC
MWRES
RC
SL
SS

Arc of Williamson County
1320 West Main, Suite 114
Franklin, Tennessee 37064
Phone: (615) 790-5815 Fax: (615) 790-5815
Director: Sharon Bottorff
Chairperson: Dara Howe

FS
ISC

Buffalo River Services, Inc.
P. O. Box 847, Hog Creek Rd.
Waynesboro, Tennessee 38485
Phone: (931) 722-5401 Fax: (931) 722-5403
Director: Philip Garner
Chairperson: Tom Helton

AD
FS
MWAD
RESA
SL

Building Greater Communities, Inc. (BGC)
2813 Dogwood Place
Nashville, Tennessee 37204
Phone: (615) 385-1365 Fax: (615) 385-1250
Director: Cynthia Eason
Chairperson: Marie LaVesque

ISC

Challengers, Inc.
409 East Central Avenue
P. O. Box 941
Jamestown, Tennessee 38556
Phone: (931) 879-7590 Fax: (931) 879-1843
Director: Ken Taylor
Chairperson: Timothy P. Nelson

AD
DD
SL

Community Development Center
111 Eaglette Way
Shelbyville, Tennessee 37160
Phone: (615) 684-8681 Fax: (615) 684-9431
Director: Sarah Hunt
Chairperson: Charles L. Rich

EI
EI-H
FS
ISC

Community Living Supports of Tennessee
1503 Hatcher Lane, Suite 100
Columbia, Tennessee 38401
Phone: (931) 840-8719 Fax: (931) 840-8756
Director: Steve Jacobs
Chairperson: Sharon A. H. May, President

AD
MWAD
RC
SL

MIDDLE TENNESSEE

FUNDED SERVICES

Community Support Services, Inc.
1100 Kermit Drive, Suite 022
Nashville, Tennessee 37217
Phone: (615) 366-1125 Fax: (615) 366-0524
Director: Debbie Riddle
Chairperson: Bryce Coatney

MWAD
MWRES
RESC
SL

COMPASS Coordination, Inc.
2403 12th Avenue South
Nashville, Tennessee 37204
Phone: (615) 463-2880 E-Mail: Int:compassmtn@aol.com
Fax: (615) 463-2824
Director: Randall Moore
Chairperson: Randall Moore

ISC

DDM
3107 Park Hill Road
Murfreesboro, TN 37129
District Manager: Jim Copeland
Phone: (615) 898-8387

MWAD
SL

Developmental Services of Dickson County
P.O. Box 628
Dickson, Tennessee 37056
Phone: (615) 446-3111 Fax: (615) 446-1846
Director: Don Redden E-Mail: Int.dsdv@isdn.net
Chairperson: Julian Norman

AD
EI
FS
MWAD
MWRES
RESA
SL

Easter Seal Society of Tennessee
2001 Woodmont Boulevard
Nashville, Tennessee 37215 E-Mail: Int:generalseals@mindspring.com
Phone: (615) 292-6640 Fax: (615) 292-7206
Director: Jayne Perkins, President
Chairperson: Samuel H. Howard

AD
MWAD

First Steps, Inc.
4414 Granny White Pike
Nashville, Tennessee 37204
Phone: (615) 298-5619 Fax: (615) 292-4941
Director: Pamela Pallas
Chairperson: Jacqueline Dixson

EI

Franklin County Adult Activity Center, Inc.
P.O. Bpx 708
702 Hundred Oaks Street
Winchester, Tennessee 37398-0708
Phone: (931) 967-1377 or 967-0100 Fax: (931) 962-1483
Director: Deborah Rains
Chairperson: C. Jackson Davis

AD
MWAD
MWRES
RESA
SL

MIDDLE TENNESSEE

	FUNDED SERVICES
Goodwill Industries of Middle Tennessee 905-9th Avenue North Nashville, Tennessee 37208 Phone: (615) 742-4151 Fax: (615) 254-3901 President: David Lifsey Chairperson: John Van Mol	AD MWAD
Habilitation and Training Services 545 Airport Rd. P. O. Box 1856 Gallatin, Tennessee 37066 Phone: (615) 451-0974 Fax: (615) 451-0774 Nashville Line: 244-5528 Director: John McIntosh Chairperson: Max Head	AD EI FS MWAD MWRES RESA SL
Hilltoppers, Inc. 151 Sweeney Drive Crossville, Tennessee 38555-6068 Phone: (931) 484-2535 Fax: (931) 484-8778 Director: Stephen (Tony) Cox Chairperson: Leonard Robertson	AD MWAD MWRES RESA SL
Homeplace 1901 20th Avenue South P.O. Box 120966 Nashville, Tennessee 37212 Phone: (615) 292-8705 Fax: (615) 320-9197 Director: Chairperson: Marcie Smeck-Bryant Residential Coordinator: Lyn West (Send all mail to her)	MWRES
Impact Centers, Inc. 1209 Tradewinds Drive Columbia, Tennessee 38401 Phone: (931) 381-2114 Fax: (931) 381-8389 Director: George Riggall Chairperson: William Lindsey	AD MWAD MWRES RESA RESC SL
Independence Systems, Inc.(formerly Lawrence County Skills) 2300 W. O. Smith St. P. O. Box 743 Lawrenceburg, Tennessee 38464 Phone: (931) 762-5066 Fax: (931) 766-2059 Director: Ray Farris Chairperson: John Lancaster	AD MWAD RESA

MIDDLE TENNESSEE

FUNDED SERVICES

James Developmental Center
200 Matthew S. Hollow Road
P. O. Box 605
Waverly, Tennessee 37185
Phone: (931) 296-7755 Fax: (931) 296-7033
Director: Ruby James
Chairperson: Carolyn Ashbury

AD
EI
MWAD
MWRES
RESA
SL

K.C. Home of Clarksville (Wesley Housing Corporation)
2425 41-A By-Pass
Clarksville, Tennessee 37040
Phone: (615) 553-0177 Fax: (615) 553-0177 (call before faxing)
Director: Brett Buehrer
Chairperson: Grady Welker
Contact Person: Brian Harris, Residential Coordinator
448 Hannings Lane
Martin, Tennessee 38237
Phone: (901) 587-6324

MWRES

Kids, Inc.
50 Dayton Avenue
Crossville, Tennessee 38555
Phone: (931) 484-8306 Fax: (931) 456-5389
Director: Ronnie Webb
Chairperson: Jean Bell

EI

King's Daughters' School
412 West 9th Street
Columbia, Tennessee 38401
Phone: (931) 388-3810 Fax: (931) 388-0405
Director: Charlotte Battles
Chairperson: Randy Maxwell

EI
EI-H

Life Action of Tennessee, Inc.
2131 Murfreesboro Road, L-1
Nashville, Tennessee 37217
Phone: (615) 399-9891 Fax: (615) 399-8620
Director: Paul Medlin

SL

Luton Mental Health Services
1921 Ransom Place
Nashville, TN 37217
Phone: (615) 366-1801 Fax: (615) 366-1866
Director: Dr. Robert N. Vero
Chairperson: Randall Yearwood

MWAD

MIDDLE TENNESSEE

FUNDED SERVICES

Middle Tennessee State University — EI
Project HELP
P. O. Box 413, 206 N. Baird Lane
Murfreesboro, Tennessee 37132
Phone: (615) 898-2321 Fax: (615) 898-5538
Director: Ann Campbell
Chairperson: Duane Stucky, Vice President
Finance & Administration

Mid-TN Supported Living, Inc. — SL
1161 Murfreesboro Road
Suite 215
Nashville, Tennessee 37217
Phone: (615) 367-0592 Fax: (615) 399-8407
Director: Denine C. Hunt
Chairperson: Doria Panvini

Nashville Senior Citizens Center — SS
1801 Broadway
Nashville, Tennessee 37203
Phone: (615) 327-4551 Fax: (615) 327-4554
Director: Janet Jernigan
Chairperson: Mary Herbert Kelly

New Horizons Corporation — AD, MWAD, MWRES, RESA, SL
5221 Harding Place
Nashville, Tennessee 37217-2901
Phone: (615) 360-8595 Fax: (615) 360-3515
Director: John Redditt
Chairperson: Joe A. Carson

NIA Properties, Inc. — SE, SL
P.O. Box 30123
Clarksville, TN 37040
Phone: (931) 358-0306 Fax: (931) 358-3081
Director: Carol Stevens

Omni Vision — MWRES
101 Lea Drive
Nashville, Tennessee 37210
Phone: (615) 726-3603 Fax: (615) 726-0393
Director: Julia Bratcher (MHMR Services)
Chairperson: Charles McLeroy

Other Options, Inc. — AD, SL
Building III
11350 McCormick Road, Suite 700
Hunt Valley, Maryland 21031
Phone: (410) 527-9990 Fax: (410) 527-9998
Director: Jesse Grimm
Attn: Susan Hann
Chairperson:

MIDDLE TENNESSEE		FUNDED SERVICES
Outlook Nashville 3004 Tuggle Avenue Nashville, Tennessee 37211-2522 Phone: (615) 834-7570 Director: Chairperson: Mike Clark	Fax: (615) 834-5565	AD DD EI MWAD MWRES SL
Pacesetters, Inc. 421 Universal Drive P. O. Box 2731 Cookeville, Tennessee 38502-2731 Phone: (931) 432-6960; 432-6961 Director: Wendy Moreland Chairperson: Buckie D. Parsons, D.D.S.	Fax: (931) 432-6890	AD FS MWAD MWRES RESA
Pediatric Services of America/Kids Medical Club (formerly Kids and Nurses of Nashville, Inc.) 2001 Charlotte Avenue, Suite 100 Nashville, Tennessee 37203 Phone: (615) 321-5299 Director: Darla Bagwell	Fax: (615) 321-5181	SS
Progress, Inc. 480 Craighead St., Suite 201 P. O. Box 41005 Nashville, Tennessee 37204 Phone: (615) 297-3344, ext. 13 Director: Richard Preslor Chairperson: Bob Parker	Fax: (615) 297-5312	AD FS MWAD MWRES RC RESA SL SS
Progressive Directions 1249 Paradise Hill Road Clarksville, Tennessee 37040 Phone: (931) 647-6333 Director: Jay Albertia Chairperson: Steve Rutledge	Fax: (931) 552-3541	AD EI EI-H FS MWAD MWRES RESA
Prospect, Inc. 1301 Winter Dr. P. O. Box 1184 Lebanon, Tennessee 37087 Phone: (615) 444-0597 Director: Eric Thompson Chairperson: Jim Flood	Fax: (615) 444-1251	AD EI FS MWAD RESA

MIDDLE TENNESSEE

FUNDED SERVICES

R & D Instructional Services
501 Metroplex Drive
Suite 207
Nashville, TN 37211-3131
Phone: (615) 837-4446 Fax:
Director: Bob Jorgenson
Chairperson:

SE

REM - Tennessee
107 Music City Circle, Suite 106
Nashville, TN 37214
Phone: (615) 883-5500 Fax: (615) 883-5504
Director: Linda Sullivan
Chairperson:

MWAD
SL

Res-Care, Inc.
P.O. Box 186
723 S. Main Street
Springfield, TN 37172
Phone: (615) 345-0266 Fax: (615) 384-2364
Director: Amy Grisby
Chairperson: Theresa Sumrell

MWRES

Residential Services, Inc.
1451 Elm Hill Pike, #161
Nashville, Tennessee 37210
Phone: (615) 367-4333 Fax: (615) 360-3894
Director: Charles McLeroy
Chairperson: Jack Seaman

RESC

Rochelle Training and Habilitation Center
1020 Southside Court
Nashville, Tennessee 37203
Phone: (615) 254-0673 Fax: (615) 726-2837
Director: Harry Gramann
Chairperson: Charles M. Ingram

AD
MWAD

Rutherford County Adult Activity Center
P.O. Box 733, 1130 Haley Road
Murfreesboro, Tennessee 37130
Phone: (615) 890-4389 Fax: (615) 849-8727
Director: Betty McNeely E-Mail: Int.rcaac@bellsouth.net
Chairperson: Horace C. Beasley

AD
MWAD
MWRES
RESA
SL

Senior Services
392 Harding Place, Suite 203
Nashville, Tennessee 37211-3999
Phone: (615) 837-0700 Fax: (615) 837-1037
Director: Gail Currie
Chairperson:

AD
MWAD
MWRES
RESA

MIDDLE TENNESSEE	FUNDED SERVICES
Skills Development Services P. O. Box 1150, 704 South Washington Street Tullahoma, Tennessee 37388 Phone: (931) 455-5107 Fax: (931) 455-3372 Director: Tom Norman Chairperson: Brenda C. Hurd	AD EI MWAD MWRES RESA
Stones River Center 3350 Memorial Boulevard Murfreesboro, Tennessee 37160 Phone: (615) 895-7788 Fax: (615) 895-6999 Director: Shelly McDonald Chairperson:	AD MWAD RESA
Sunny Brook Home, Inc. 2131 Long Distance Road Lewisburg, Tennessee 37091 Phone: (931) 359-3814 Fax: (931) 359-3814 Director: Johnny Brown Chairperson: Rev. Larry Helton	RESA
Sunrise Community of Tennessee, Inc. 1410 Donelson Pike Suite A-20 Nashville, Tennessee 37217 Phone: (615) 366-7535 Fax: (615) 366-7428 Director: Tina Veale Chairperson: Leslie W. Leech, Jr.	SL
Susan Gray School for Children Vanderbilt University Peabody Campus P.O. Box 66 Nashville, Tennessee 37203 Phone: (615) 322-8200 Fax: (615) 322-8236 Director: Chairperson: Ann Marie Deer Owens	EI
Tennessee Mentor, Inc. 214 Centerview Drive Suite 265 Brentwood, Tennessee 37027 Phone: (615) 376-6333 Fax: (615) 376-6039 Director: Michael Hamlet Chairperson:	SL MWRES
Tennessee Technological University P. O. Box 5037 Cookeville, Tennessee 38501 Phone: (615) 372-3555 Fax: (615) 372-3898 Director: Eloise Jackson, Ph.D. Chairperson: Angelo A. Volpe (615) 372-3374	EI-H

MIDDLE TENNESSEE	FUNDED SERVICES
Vanderbilt University - Child Development Center *ATTN: Pat Cherry, Admin. Secretary* 2100 Pierce Avenue, Room 426 Nashville, Tennessee 37232-3573 Phone: (615) 936-0249 Fax: (615) 936-0256 Director: Mark Wolraich, M. D. Assoc. Dir: Angie Thompson, Med. Ctr. South Chairperson: William Cook	D & E
VOCA Corporation Tennessee Regional Office 211 Donelson Pike, Suite 11 Nashville, Tennessee 37214 Phone: (615) 874-0011 Fax: (615) 874-0511 Director: Heidi Parworth Chairperson: (Hdqt: Dublin, OH)	RESA
Volunteers of America TN 500 Interstate Boulevard, Suite 101 Nashville, Tennessee 37210 Phone: (615) 256-6884 Fax: (615) 256-6255 Director: Beverly Collins Chairperson: Charles Fulner	MWAD SL
Waves, Inc. P.O. Box 1225 Franklin, Tennessee 37065-1225 Phone: (615) 794-7955 Fax: (615) 794-6019 Exec. Director: Jennifer Krahenbill Chairperson: Tom Steams	AD EI MWAD MWRES RESA SL

WEST TENNESSEE

FUNDED SERVICES

C. S. Patterson Training and Habilitation Center, Inc.
1284 Highway 45 By-Pass N.
P. O. Box 229
Trenton, Tennessee 38382
Phone: (901) 855-2316 Fax: (901) 855-3608
Director: Harry Adcock E-Mail: Int:haexptc@iswt.com
Chairperson: R. L. Radford

AD
EI
EI-H
FS
MWAD
MWRES
RESA
SL

Carroll County Developmental Center
13345 Paris Street
Huntingdon, Tennessee 38344-2523
Phone: (901) 986-8914 Fax: (901) 986-5469
Director: Barbara Gray E-Mail: Int:ccdc@iswt.com
Chairperson: Dr. Laddie Lollar

AD
FS
MWAD
MWRES
RESA
SL

Children and Family Services, Inc.
412 Alston Avenue
P. O. Box 845
Covington, Tennessee 38019-0845
Phone: (901) 476-2364 Fax: (901) 476-2368
Director: Minnie Bommer
Chairperson: Barbara Grandberry

EI

Community Developmental Services, Inc.
455 Hannings Lane
Martin, Tennessee 38237-3390
Phone: (901) 587-3851 Fax: (901) 587-0548
Director: Cathy Cate E-Mail: Int:cdsrvs@pluto.utm.edu
Chairperson: Jim Wheatley
(Specify to whom you are sending information.)

AD
FS
MWAD
MWRES
RESA
SL

COMPASS Coordination, Inc.
(Serving Middle & West Tennessee)
3251 Poplar Avenue, Suite 230
Memphis, TN 38111-3609
Phone: (901) 327-1040 Fax: (901) 327-1141
Director: Randall Moore E-Mail: Int.compasscor@aol.com
Chairperson: Randall Moore

ISC

Cornerstone (formerly Benton County Developmental Services)
207 Hwy. 641 North
P.O. Box 486
Camden, Tennessee 38320
Phone: (901) 584-2002 Fax: (901) 584-8645
Director: Ricky Allen
Chairperson: Bill Kee

AD
FS
MWAD
MWRES
SL

WEST TENNESSEE

FUNDED SERVICES

Developmental Disabilities Dental Clinic — SS
34 Garland Drive
Jackson, Tennessee 38305
Phone: (901) 668-3573 Fax: (901) 668-3583
Director: Diane Britt
Chairperson: Dr. O. Chester Jones

Down Syndrome Association of Memphis, Inc. — EI
Special Kids & Families, Inc. — EI-H
P.O. Box 22383
Memphis, Tennessee 38122
Phone: (901) 324-7050 Fax: (901) 324-1285
Director: JoAnn Hinkle
Chairperson: Catherine Clippard, President

Dungarvin, Inc. of TN — MWAD, MWRES
6061 Stage Road, Suite 3
Memphis, TN 38134 E-Mail: lnt:jsmrt@aol.com
Phone: (901) 382-6515 Fax: (901) 392-9032
Director: Judy Smrt
Chairperson: Tim Madden

Easter Seal Developmental Services — AD, FS, MWAD, MWRES, SL
99 Monroe Avenue
Lexington, Tennessee 38351
Phone: (901) 968-6037 Fax: (901) 967-1512
Director: Judy Bowman
Chairperson: Samuel H. Howard

Fayette County Development Center, Inc. — AD, MWAD
P. O. Box 339
Somerville, Tennessee 38068 E-Mail: lnt:fayyum@juno.com
Phone: (901) 465-3364 Fax: (901) 465-5193
Director: Shirley Lee
Chairperson: Cliff Henderson, Jr.

Hardeman County Developmental Services Center, Inc. — AD, EI, MWAD, MWRES, RESA
208 Hope Street
Bolivar, Tennessee 38008
Phone: (901) 658-4403 Fax: (901) 658-3280
Director: Thomas Addcox
Chairperson: Hazel Bills

Hardin County Skills — MWAD, MWRES
1821Northwood Drive
P. O. Box 666
Savannah, Tennessee 38372
Phone: (901) 925-4039 Fax: (901) 925-5679
Director: Anna Robinson
Chairperson: Brent Grimes

WEST TENNESSEE	FUNDED SERVICES
Harwood Training Center, Inc. 711 Jefferson Avenue Memphis, Tennessee 38105 Phone: (901) 448-6580 Fax: (901) 448-4734 Director: Anne Wieties Chairperson: William E. Loveless	EI-H
Helen R. Tucker Adult Developmental Center P.O. Box 648 Ripley, Tennessee 38063 Phone: (901) 635-4290 Fax: (901) 635-8975 Director: Clayton Pattat Chairperson: Helen Tucker	AD FS MWAD RESA
Kiwanis Center for Child Development, Inc. 32 Garland Drive Jackson, Tennessee 38305 Phone: (901) 668-9070 Fax: (901) 668-6549 Director: Dale Brittain Chairperson: Bill Taylor	EI EI-H
Le Bonheur Children's Medical Center 50 North Dunlap Street (March 1998) Memphis, Tennessee 38103 Phone: (901) 572-67347 Fax: (901) 572-5261 VP of Operations: Janice Marks Chairperson: Ronald Walter	EI
Madison/Haywood Developmental Services Center P.O. Box 11205 Jackson, Tennessee 38308-0120 E-Mail: lnt:mhdsjackson51@hotmail.com Phone: (901) 664-0855 (213 Cheyenne Drive, Jackson, TN 38305) Phone: (901) 664-5857 (38 Garland Drive) Fax: (901) 668-2973 Director: Bob Ellis Chairperson: Paula Butler	AD FS MWAD MWRES RESA
McNairy County Developmental Services 393 South Sixth Street Selmer, Tennessee 38375 Phone: (901) 645-7730 Fax: (901) 645-9118 Director: Quinnie Bell Chairperson: S. Craig Kennedy	AD MWAD MWRES RESA SL
Mid-South Association for Retarded Citizens 3485 Poplar Avenue, Suite 225 Memphis, Tennessee 38111 Phone: (901) 327-2473 Fax: (901) 327-2687 Director: Carlene Leaper Chairperson: Connie Booker	RC

WEST TENNESSEE

FUNDED SERVICES

Omni Vision, Inc.
101 Lea Avenue
Nashville, Tennessee 37210
Phone: (615) 726-3603 Fax: (615) 726-0393
Exec. Director: James M. Henry
Director: Julia Bratcher (MHMR Services)
Chairperson: Charles McLeroy

MWRES

Other Options, Inc.
250 North Parkway, Suite 26
Jackson, Tennessee 38305
Phone: (901) 664-5767 Fax: (901) 664-7473
Director: Caterina Pangilinan
Chairperson:

SL

Porter Leath Children's Center
868 North Manassas
Memphis, Tennessee 38107 E-Mail: lnt:janew@porter-leath.com
Phone: (901) 577-2500 Fax: (901) 577-2506
Director: David Hansen
Chairperson: Ms. Shanne Porter

SS

QUEST of Tennesse
P.O. Box 1300
Apopka, FL 32704
Phone: (407) 889-4530 Fax: (407) 889-5710
Director: Alan Fidelo
Chairperson: Katie Porta

RESA
RESC

R&D
250 N. Parkway, Suite 26
Jackson, TN 38305
Phone: (901) 664-5767 Fax: (901) 664-7473
Director: David Bell

SE

REM - Tennessee, Inc.
8299 Sturbridge Way, Room 304
Cordova, Tennessee 38018 E-Mail:
Phone: (901) 737-9917 Fax:
Director: Cyndi Bergs
Chairperson:

MWAD
SL

RHA - Resource Housing of America/Tennessee Group Homes, Inc.
Managed by:
DDM - Developmental Disabilities Management Services
RHA/Tennessee Group Homes, Inc.
5050 Poplar Avenue, Suite 1800
Memphis, Tennessee 38157 E-Mail: lnt.ddms@netten.net
Phone: (901) 767-1455 Fax: (901) 767-1409
Director:
Chairperson: Bryant Coates
Send mail to Art Trunkfield, Chief Operating Officer

MWAD
SL

WEST TENNESSEE — FUNDED SERVICES

Senior Services — MWRES
4700 Poplar Avenue, Suite 100
Memphis, Tennessee 38117-4411 E-Mail: Int:srservic@memphisonline.com
Phone: (901) 766-0600 Fax: (901) 766-0699
Director: Deborah Cotney
Chairperson:

Shelby Residential and Vocational Services, Inc. — AD, FS, MWAD, MWRES, RESA
3592 Knight Arnold
Memphis, Tennessee 38118-2700
Phone: (901) 375-4804 Fax: (901) 362-1891
Director: Jeffrie Bruton
Chairperson: Christine B. Munson

STAR Center — SS
60 Lynnoak Cove
Jackson, Tennessee 38305 E-Mail: Int:mllane@starcenter.tn.org
Phone: (901) 668-9695 Fax: (901) 668-1666
Director: Margaret Doumitt
Chairperson:

Sunrise Community of Tennessee, Inc. — SL, MWAD
7531 Bartlett Corporate Cove East
Suite 104
Bartlett, Tennessee 38134
Phone: (901) 386-8305 Fax: (901) 373-2543
Exec. Director: Brenda O'Quinn
Director: Janet TorresMartinez
Chairperson: Leslie W. Leech, Jr.

T.A.P., Inc. (The Alternative Program, Inc.) — ISC
207 National Drive, Apt. 97
Murfreesboro, Tennessee 37128
Phone: (615) 907-0305 Fax:
Director: Scot Booth
Director of Operations: Kim Hancock
Chairperson: John Schukle

Team Evaluation Center (Memphis Office) — D & E
777 Washington Avenue, Suite 340
Memphis, Tennessee 38103
Phone: (901) 572-3212 Fax: (901) 572-5320
Director: Alan Bullard
Administrator: Ann Beckham (send all mail to Ann)
Chairperson: Father James Marquis

Tennessee Mentor — SL
65 Germantown Court, Suite 112
Cordova, Tennessee 38018
Phone: (901) 753-0055 Fax: (901) 753-0206
Director: Kim Daugherty

WEST TENNESSEE — FUNDED SERVICES

United Methodist Neighborhood Centers — EI
Susannah Center
P. O. Box 111348
Memphis, Tennessee 38111-1348
Phone: (901) 323-4993 Fax: (901) 323-5264
Exec. Director: Karen Carothers
Program Dir: Alma Boyd
Chairperson: Marilyn Mukievicz

University of Tennessee at Martin — EI
Infant Stimulation Program — EI-H
340 Gooch Hall
Martin, Tennessee 38238-5045 E-Mail: Int:swenz@utm.edu
Phone: (901) 587-7115 Fax: (901) 587-7109
Director: Sharon Wenz
Chairperson: Dr. Martha Herndon

The University of Memphis — EI
Project Memphis (Barbara K. Lipman School)
3771 Poplar Avenue
Memphis, Tennessee 38152 E-Mai: Int:gaboyd@cc.memphis.edu
Phone: (901) 678-2120 Fax: (901) 678-4778
Director: Dr. Gwendolyn Boyd
Chairperson: Dr. Lane Rawlins, University President

Vision Coordination Services, Inc. — ISC
885 S. Cooper Street
Memphis Tennessee 38104
Phone: (901) 722-2470 or pager 1-888-650-7013 Fax: (901) 722-2471
Director: Cedric Deadmon
Chairperson: Cedric Deadmon

VOCA Corporation — MWAD
211 Donelson Pike
Suite 11 SL
Nashville, Tennessee 37214
Phone: (615) 874-0011 Fax: (615) 874-0511
Director: Heidi Parworth
Chairperson:

Wesley Housing Corporation of Memphis — MWRES
400 South Highland Avenue
Memphis, Tennessee 38111
Phone: (901) 325-7800 Fax: (901) 325-7802
Director: Jerry Cordew
Chairperson: Randal Tomblin

West Tennessee Cerebral Palsy Association, Inc. — AD
34 Garland Drive
Jackson, Tennessee 38305
Phone: (901) 668-3322 Fax: (901) 664-2941
Director: Allen Dunn
Chairperson: Mickey Hannon

STATEWIDE SERVICES	FUNDED SERVICES
The Arc of Tennessee 1719 West End Avenue, Suite 300E Nashville, Tennessee 37203 Phone: (615) 327-0294 Fax: (615) 327-0827 Director: Mike Remus Chairperson: Donald Redden	ST
Community Rehabilitation Agencies of Tennessee, Inc. 530 Church Street, Suite 504 Nashville, Tennessee 37219 Phone: (615) 254-3077 Fax: (615) 254-3078 Director: Mindy Schuster Chairperson: Kyle Hauth	ST (DD)
People First of Tennessee, Inc. 855 West College Street Unit D Murfreesboro, TN 37129 Phone: (615) 898-0075 Fax: (615) 898-0057 Director: Ruthie-Marie Beckwith, Ph.D. Chairperson: Edward Sewell	ST
Tennessee Alliance on Support Coordination - TASC 2403 12th Avenue South Nashville, Tennessee 37204 Phone: (615) 463-2880 Fax: (615) 463-2824 Director: Randall Moore Chairperson: Randall Moore	ST
Tennessee Disability Coalition 480 Craighead Avenue, Suite 200 Nashville, Tennessee 37204 (Mailing address: P.O. Box 120773) Phone: (615) 383-9442 Fax: (615) 383-1176 Director: Carol Westlake Chairperson: Joe Marshall	ST
Tennessee Special Olympics 112 - 21st Avenue South, Suite 101 Nashville, Tennessee 37203 Phone: (615) 322-8292 Fax: (615) 343-9473 Director: Alan L. Bolick Chairperson: David Schwab	ST

STATEWIDE SERVICES

FUNDED SERVICES

ST

University of Tennessee
TIE (Technology Inclusion Employment)
1914 Andy Holt Avenue
B025 HPER Building
Knoxville, Tennessee 37996-2750
Phone: (423) 974-9400 Fax: (423) 974-9180
Director: Carolyn Henderson
Assoc. Dir.: Debra Martin

Vocational Rehabilitation Services

Department of Human Services – Vocational Rehabilitation

Vocational Rehabilitation is a federal/state funded program providing services to help individuals (ages 16 and above) with disabilities enter or return to employment. It is designed to help individuals of work age with disabling physical and/or mental impairments compete successfully with others in earning a livelihood. Only the Division of Rehabilitative Services can make the decision for eligibility. Medical examinations, psychosocial examinations or vocational evaluations are secured by this division to determine the nature and extent of the disability and to assist the Vocational Rehabilitation Services counselor in evaluating the individual's work potential and jointly selecting an occupational goal consistent with this potential.

Offices in the Division of Rehabilitative Services:

Region 1:

Regional Supervisor 905 Buffalo Street Johnson City, TN 37064	423/929-9142
Rehabilitative Services 103 East Walnut Street Johnson City, TN 37601	423/929-3178
Rehabilitation Services 201 Cherokee Street Kingsport, TN 37662	423/245-4278
Rehabilitation Services 241 Baileytown Road Greeneville, TN 37743	423/639-5148
Rehabilitation Services Corner of E & Roan Street Elizabethton, TN 37643	423/542-4159

Region 2:

Regional Supervisor State Office Building, Suite 303B 531 Henley Street Knoxville, TN 37902	423/594-6720
Rehabilitation Services Harriman Early Childhood Center P.O. Box 949 Harriman, TN 37748	423/882-1475
Rehabilitation Services 2418 North Morelock Road Morristown, TN 37814	423/587-7008

Rehabilitation Services
Tennessee School for the Deaf
2725 Island Home Road
Knoxville, TN 37920 — 423/594-6154 (voice/TTY)

Region 3:

Regional Supervisor
1501 Riverside Drive
Chattanooga, TN 37406 — 423/493-6056

Rehabilitation Services
290 Durkee Road, SE
Cleveland, TN 37311 — 423/478-0328

Rehabilitation Services
444 Neal Street, East
Cookeville, TN 38501 — 931/526-9783

Rehabilitation Services
Highway 52 Bypass
Lafayette, TN 37083 — 931/666-2179

Rehabilitation Services
125 Belmont Drive
McMinnville, TN 37110 — 931/473-4667

(no Region 4)

Region 5:

Regional Supervisor
88 Hermitage Avenue
Nashville, TN 37210 — 615/741-1606

Rehabilitation Services
1099 Cairo Road
Gallatin, TN 37066 — 615/451-5827

Rehabilitation Services
1405 A Brookwood Avenue
Franklin, TN 37064 — 615/790-5506

Rehabilitation Services
1241 Highway Drive
Clarksville, TN 37040 — 931/648-5560

Goodwill Industries
905 9th Avenue North
Nashville, TN 37208 — 615/742-4151

Region 6:

Regional Supervisor
209 Wayne Street
Columbia, TN 38401 — 931/380-2563

Rehabilitation Services
1132 Haley Road
Murfreesboro, TN 37129 — 615/898-8084

Rehabilitation Services
1304 Railroad Avenue
Shelbyville, TN 37160 — 931/685-5019

Rehabilitation Services
135 Baxter Lane
Winchester, TN 37398 — 931/967-7738

Rehabilitation Services
1200 Oakdale Street
Manchester, TN 37355 — 931/723-5072

Rehabilitation Services
2221 Thornton Taylor Parkway
Fayetteville, TN 37334 — 931/433-4826

Rehabilitation Services
237 East Taylor Street
Lawrenceburg, TN 37464 — 931/762-3486

Region 7:

Regional Supervisor
225 Martin Luther King Boulevard
Suite 104-A, Box 15
Jackson, TN 38301 — 901/423-5620

Rehabilitation Services
1979 St. John Avenue
Dyersburg, TN 38024 — 901/286-8315

Rehabilitation Services
314 Florida Street
Union City, TN 38261 — 901/884-2600

Rehabilitation Services
508 North Market Street
Paris, TN 38242 — 901/664-7361

Rehabilitation Services
168 South Forrest
Camden, TN 38320 — 901/584-2147

Rehabilitation Services
724 Highway 51 North
Covington, TN 38019 901/475-2505

Rehabilitation Services
2100 Wayne Road
Savannah, TN 38372 901/925-4968

(no Region 8)

Region 9:

Regional Supervisor
170 North Main, Room 802
Memphis, TN 38103 901/543-7301

Tennessee Vocational Training Centers:

A network of Vocational Training Centers is established throughout the state, with cooperation and partial funding from local governments. Usually located in rural areas, these services complement the more extensive rehabilitation and related service facilities of the state's larger cities. These facilities provide vocational evaluation, adjustment, and placement services for individuals with disabilities.

Tennessee Vocational Training Centers include:

168 South Forrest Avenue
Camden, TN 38320 901/584-7015

1241 Highway Drive
Clarksville, TN 37040 931/648-5560

2895 Bates Pike SE
Cleveland, TN 37323 423/478-0332

206 Wayne Street
Columbia, TN 38401 931/380-2550

1605 Brown Avenue
Cookeville, TN 38501 931/526-4721

1979 St. John Avenue
Dyersburg, TN 38024 901/286-8313

Corner of E & Roan Street
Elizabethton, TN 37643 423/542-4159

1405A Brookwood Avenue
Franklin, TN 37064 615/790-5509

1099 Cairo Road
Gallatin, TN 37066 615/451-5826

241 Baileyton Road Greeneville, TN 37743	423/639-5148
Highway 52 Bypass Lafayette, TN 37083	931/666-2179
1200 Oakdale Street Manchester, TN 37355	931/723-5070
1627 Percheron Street Maryville, TN 37801	423/981-2382
2418 North Morelock Road Morristown, TN 37814	423/587-7006
1132 Haley Road Murfreesboro, TN 37129	615/898-8088
150 Rison Street Paris, TN 38242	901/644-7363
1304 Railroad Avenue Shelbyville, TN 37160	931/685-5017
314 Florida Street Union City, TN 38261	901/884-2600
135 Baxter Lane Winchester, TN 37398	931/967-4511

Residential Vocational Rehabilitation Facility:
The Tennessee Rehabilitation Center in Smyrna is the state's only comprehensive residential vocational rehabilitation facility. Five service delivery programs are offered which are designed to meet the needs of Rehabilitation Services clients: comprehensive rehabilitation evaluation, work adjustment, vocational training, medical rehabilitation and visually impaired services.

Tennessee Rehabilitation Center 460 9th Avenue Smyrna, TN 37167	615/741-7921

Alcohol and Drug Abuse Services

Department of Health – Alcohol and Drug Abuse Services

The problems of chemical dependency and substance abuse impact everyone whose lives are touched by these issues. The Division of Alcohol and Drug Abuse Services funds treatment, intervention and rehabilitation services through community-based outpatient and residential treatment facilities across the state. Targeted activities designed to prevent alcohol and other drug abuse among youth and adults are conducted regularly.

Treatment Programs
To contact this Division for further information, call 615/741-1921.

Adolescent Residential Treatment:
Adolescent residential treatment services are designed to restore the severely dysfunctional alcohol and other drug dependent youth (ages 13-18) to levels of positive functioning appropriate to the individual. Residents will usually live in the facility around the clock from three to six months.

Adolescent Day Treatment:
Adolescent day treatment provides care and treatment during the day and/or evening hours for abusers of alcohol and other drugs who are 13-18 years of age. The average length of participation is 6-12 month, 5 days a week, 4 hours a day. Day programs may also include academic services.

Dual Diagnosis Programs:
Dual Diagnosis Programs assist clients in receiving treatment for both disorders, mental illness and chemical dependency, with the emphasis placed upon identifying and treating the primary diagnosis.

Family Intervention and Referral Service:
This service provides a structured treatment program that provides short-term counseling and intervention to members of the family who reside with a person who is actively dependent, as well as the chemically dependent person.

Prevention Services:
To contact this Division for further information, call 615/741-1921.

Intensive Focus Group Programs:
Intensive focus group programs are structured, short-term (12 weeks) education counseling programs for youth and their families. Programs target youth (10-18 years of age) identified as high risk for developing alcohol and other drug problems and/or high risk to develop unhealthy living patterns due to negative impacts of the environment they live in. At least one intensive focus group program available for every county statewide.

Tennessee Teen Institutes:
Tennessee Teen Institute is a weeklong training and personal development program designed to prepare youth for a leadership role in the development of school and community based prevention programming.

Statewide Clearinghouse:

The Statewide Clearinghouse serves as a centralized resource for materials and information that is easily accessible by local and toll-free telephone numbers. The toll-free number for Tennessee Redline is 1-800/889-9789 or the local number is 615/244-7066. The Tennessee Redline serves as a referral source for individuals requiring information or treatment. Redline services provide 12 hour telephone services, 5 days a week, which are available to the general public.

Services Offered by the Department of Children's Services

Department of Children's Services

The Department of Children's Services provides a full range of services to children in, and at risk of, state custody and their families.

Through a variety of public and private agencies, administered in a managed care environment, the department is responsible for:

- Child protective services,
- Foster care,
- Adoption,
- Programs for delinquent youth,
- Probation,
- Aftercare,
- Treatment and rehabilitation programs for identified youth, and
- Licensing for all child-welfare agencies.

The agency's main office may be reached by calling 615/741-9699.

Listings for Providers, Community Residential Programs, and Departmental Treatment Facilities follow.

PROVIDER DIRECTORY LIST

Agape Child and Family Services, Inc. P.O. Box 11411 Memphis, TN 38111 901-272-7339	AGAPE, Inc. 4555 Trousdale Nashville, TN 37204 615-781-3000	American Counseling System P.O. Box 309 603 West Main Hohenwald, TN 38462 931-796-2039
American Family Institute P.O. Box 948 Chattanooga, TN 37401 423-266-6939	American Family Institute 1314 Chamberlain Avenue Chattanooga, TN 37404 423-266-6939	Associated Catholic Charities of E TN, Inc. 119 Dameron Dr. Knoxville, TN 37917 423-524-9896
Bachman Memorial Home, Inc. P.O. Box 849 Cleveland, TN 37364 423-479-4523	Bethany Home 901 Chelsea Ave. Memphis, TN 38107 901-525-1837	Bethel Bible Village P.O. Box 5000 3001 Hamil Road Hixson, TN 37343 423-824-5757
Blount County Children's Home< 903 McCammon Ave. Maryville, TN 37801 423-982-6361	Camelot Care Centers, Inc. 659 Emory Valley Road Oakridge, TN 37830 423-481-3972	Carent, Inc. 1220 8th Ave S. Nashville, TN 37203 315-742-3000
Carey Counseling Center/Group Home 408 Virginia Street P.O. Box 30 Paris, TN 38242 901-642-0521	Catholic Charities St. Peter Home for Children 3060 Baskin Memphis, TN 38127 901-354-6300	Central Appalachia Services, Inc. P.O. Box 30809 Kingston, TN 37662 423-578-3900
Charter Lakeside 2911Brunswick Road Memphis, TN 38133 901-377-4701	Child & Family Services, Inc. 901 East Summit Hill Drive Knoxville, TN 37915 423-524-7483	Child Shelter, Inc. 500 Tasso Lane, NE Cleveland, TN 37312 423-479-2520
Children's Home Chambliss Shelter 315 Gillespie Road Chattanooga, TN 37411 423-698-2456	Church of God Home for Children P.O. Box 4391 Sevierville, TN 37864 423-453-4644	Columbia Valley Hospital 2200 Morris Hill Road Chattanooga, TN 37421 423-894-4220
Corrections Corp. of America 10 Burton Hills Dr Suite 800 Nashville, TN 37215 615-292-3100	DeDe Wallace Center P.O. Box 70189 Nashville, TN 37207 615-463-6627	DeNeuville Heights School 3060 Baskin Street Memphis, TN 38127 901-357-7316
Dyersburg-Dyer County Union Mission P.O. Box 179 Dyersburg, TN 38025-0179 901-285-0726	East Tennessee Christian Home P.O. Box 1147 Elizabethan, TN 37644 423-542-4423	East TN Christian Services, Inc. P.O. Box 52703 Knoxville, TN 37950 423-584-0841

Eckerd Family Youth Alternatives 421 Catfish Farm Road Deerlodge, TN 37726 931-863-5366	Emergency Child Shelter, Inc. 208 Parkway Blvd. Elizabethton, TN 37643 423-543-6696	Family & Children's Services of Chattanooga 300 East 8th Street Chattanooga, TN 37403 423-755-2808
Family& Children's Services of Nashville 201 23rd Avenue North Nashville, TN 37203 615-320-0591	Family & Educational Advisory Associates 100 Oaks Office Tower 719 Thompson Lane Suite 600 Nashville, TN 37204 615-383-2232	Family Link 1528 Poplar Memphis, TN 38104 901-752-6911
FHC Nashville 804 Youngs Lane Nashville, TN 37207 615-228-4848	First Tennessee Human Resource Agency 112 East Myrtle Ave., Suite 101 Johnson City, TN. 37601 423-461-8209	Free Will Baptist Family Ministries, Inc. 90 Stanley Lane Greeneville, TN 37743 423-639-9449
Gateway House, Inc. P.O. Box 220 Louisville, TN 37777 423-983-8603	Genesis Learning Centers 430 Allied Drive Nashville, TN 37211 615-832-4222	Glen Mills School Glen Mills Road Concordville, PA 19331 610-459-8100
Goodwill Homes Community Services, Inc. P.O. Box 161282 Memphis, TN 38186-1282 901-785-6790	Greater Chattanooga Christian Services P.O. Box 4535 Chattanooga, TN 37405 423-756-0281	Guidance Center 118 North Church Street P.O. Box 1559 Murfreesboro, TN 37133 615-893-0770
Happy Haven Homes 2311 Wakefield Dr. Cookeville, TN 38501 931-526-2052	Happy Hills Boys Ranch 1115 Ranch Road Ashland City, TN 37015 615-307-3205	Harriet Cohn Mental Health Center 511 8th Street Clarksville, TN 37040 931-648-8126
Holston United Methodist Home for Children P.O. Box 188 Greeneville, TN 37744 423-638-4171	Jabneel, Inc. P.O. Box 690 Powell, TN 37849 423-687-6141	Jackson Academy 222 Church Street Dickson, TN 37055 615-446-3900
John Tarleton Home 2455 Sutherland Avenue Knoxville, TN 37919 423-525-6154	Joseph W. Johnson Jr. Mental Health Center, Inc. P.O. Box 4755 Chattanooga, TN 37405-0735 423-756-2740	Kingswood School P.O. Box 5000 Bean Station, TN 37708 423-767-2121
Lewis Ambulatory Care Center, Ambulatory Care Center, New Hope D & E 617 West Main Street Hohenwald, TN 38462 615-381-1111 ext. 1000	Lutheran Family Services of TN 3508 Maryville Pike Knoxville, TN 37920 423-579-0039	Madison Children's Home P.O. Box 419 Madison, TN 37116-0419 615-860-4416

Magnolia Health & Education Route 6, Box 221-A Columbia, TN 38401 615-377-8715	Memphis Recovery Centers 219 North Montgomery Memphis, TN 38104 901-272-7751	Metro Social Services Richland Village 25 Middleton Street Nashville, TN 37210 615-862-6432
Middle Tennessee Mental Health Institute 221 Stewarts Ferry Pike Nashville, TN 37214 615-902-7535	Midtown Mental Health Center, Inc. 427 Lynden Memphis, TN 38126 901-577-9463	Moccasin Bend Mental Health Institute Moccasin Bend Road Chattanooga, TN 37405 423-785-3400
Monroe Harding Children's Home 1120 Glendale Lane Nashville, TN 37204 615-298-5573	Mur-Ci Homes, Inc. P.O. Box 735 Antioch, TN 37011 615-641-6446	My Friends House 626 Eastview Drive Franklin, TN 37064 615-790-8919
New Life Home, For Boys Inc. P.O. Box 15676 Chattanooga, TN 37415 423-877-7897	New Life Youth Home Dyersburg Dyer County Union Mission 250 Youth Home Rd. Dyersburg, TN 38024 901-286-1866	Oasis Center, Inc. P.O. Box 121648 Nashville, TN 37212 615-327-4455
Omni Visions 101 Lea Avenue Nashville, TN 37210 615-726-3603	Pathways of Tennessee, Inc. 238 Summar Drive Jackson, TN 38301 901-935-8320	Peninsula Healthcare System P.O. Box 2000 Louisville, TN 37777 423-970-1881
Plateau Mental Health Center P.O. Box 3165 Cookeville, TN 38502-3165 423-756-2740	Porter-Leath Children's Center 868 North Manassas Memphis, TN 38107 901-577-2500	Progress, Inc. (Our House) P.O. Box 10045 Nashville, TN 37204 615-297-3344
Quinco Community Mental Health 10710 Highway 64 West Bolivar, TN 38008 901-658-6113	Recovery Residences 217 24th Ave North Nashville, TN 37203 615-353-4385	Residential Services, Inc. 1451 Elm Hill Pike, Suite 161 Nashville, TN 37210-4523 615-367-4333
Senior Citizens Services, Inc. 4700 Poplar Avenue, Suite 100 Memphis, TN 38117 901-766-0600	Sullivan County Youth Center 852 Youth Center Road Blountville, TN 37617 423-279-2718	Tennessee Children's Home P.O. Box 10045 Spring Hill, TN 37174 931-486-2274
The Florence Crittenton Agency, Inc. 1531 Dick Lonas Road Knoxville, TN 37909 423-602-2021	The King's Daughters' School 412 West 9th Street Columbia, TN 38401 931-388-3810	Trac, Inc. 220 S. Hickory Street Gallatin, TN 37066 615-451-2154
Triad Children & Youth Services 204 E. Spring Street Cookeville, TN 38501 931-528-8370	Upper Cumberland Human Res. 3111 Enterprise Dr. Cookeville, TN 38506 931-528-1127	Upper Cumberland Teen Ranch 355 Mayland Loop Crossville, TN 38555 931-277-3024

Watauga Mental Health Services, Inc. 109 West Watuaga Avenue P.O. Box 2226 Johnson City, TN 37605 423-928-6546	Wayne Halfway House 1117 Santa Hwy Waynesboro, TN 38485 931-722-3272 or 9976	West Tennessee Children's Home 170 Frank Latham Rd. Pinson, TN 38366 901-989-7335
Western Mental Health Institute 11100 Highway 64 Western Institute, TN 38074 901-658-5141	Wilson County Youth Emergency Shelter 553 Victor Avenue Lebanon, TN 37087 931-443-7222	Youth Emergency Shelter 407 West 5th Street North Morristown, TN 37814 423-586-7740
Youth Services Inc. P.O. Box 6012 Oak Ridge, TN 37831	Youth Services International of Tennessee, Inc. 5908 Lyons View Drive Jane Keller Building Knoxville, TN 37919 423-584-5630	Youth Town of Tennessee, Inc. P.O. Box 1385 Jackson, TN 38302 901-988-5251
Youth Villages P.O. Box 341154 Memphis, TN 38184 901-867-8832		YWCA Try Angle House 1608 Woodmont Blvd. Nashville, TN 37215 615-269-9922

Send Comments to : Department of Children's Services

Community Residential Programs

NORTHEAST TENNESSEE REGION

Northeast Tennessee Academy (N.E.T. Academy) Department of Children's Services 200 Quarry Road Johnson City, Tennessee 37601 (423) 929-8300 Fax: (423)434-6496	Johnson City Boys Group Home Department of Children's Services 208 Quarry Road Johnson City, Tennessee 37601 (423) 929-8101 Fax: (423) 928-8632
Elizabethton Group Home * Department of Children's Services 150 Hatcher Lane Elizabethton, Tennessee 37643 (423) 543-1871 Fax: (423) 547-0913	Johnson City Observation & Assessment Center Department of Children's Services 210 Quarry Road Johnson City, Tennessee 37601 (423) 929-1240 Fax: (423) 434-6497
L.I.F.T Academy ** Department of Children's Services Route 1, Box 2965 Elizabethton, Tennessee 37643 (423) 547-4050 Fax: (423)547- 4061	

EAST TENNESSEE REGION

Madisonville Group Home * Department of Children's Services 249 Wayman Road Madisonville, Tennessee 37354 (423) 442-7411 Fax: (423) 442-7413	Oak Ridge Group Home Department of Children's Services 125 Lancaster Road Oak Ridge, Tennessee 37830 (423) 483-1170 Fax: (423) 483-9793

UPPER CUMBERLAND REGION

Cookeville Halfway House Department of Children's Services 1230 North Willow Cookeville, Tennessee 38501 Fax: (423) 528-9299

DAVIDSON COUNTY REGION

Nashville Transition Center Department of Children's Services 2412 Plum Street Nashville, Tennessee 37207 (615) 741-1505 Fax: (615) 227-5307

SOUTHWEST REGION

Jackson Halfway House
Department of Children's Services
235 North Highland Avenue
Jackson, Tennessee 38301
(901) 423-6654
Fax: (901) 426-0533

SHELBY COUNTY REGION

Memphis Group Home
Department of Children's Services
305 North Bellevue
Memphis, Tennessee 38301
(901) 726-6872
Fax: (901) 726-0174

Peabody Residential Treatment Center
Department of Children's Services
1242 Peabody Avenue
Memphis, Tennessee 38104
(901) 543-7943
Fax: (901) 276-1406

* Denotes programs for girls only
** Denotes programs for girls and boys

Send Comments to : Department of Children's Services

Departmental Treatment Facilities Directory

Woodland Hills Youth Development Center** Department of Children's Services 3965 Stewarts Lane Nashville, Tennessee 37243-1297 (615) 532-2000 Fax: (615) 532-8402 Superintendent: Ken Curry	Taft Youth Development Center Department of Children's Services Route 4, Box 400 Pikeville, Tennessee 37367 (423) 881-3201 Fax: (423) 881-4617 Superintendent: Larry Lively
Wilder Youth Development Center Department of Children's Service P.O. Box 639 13870 Highway 59 Somerville, Tennessee 38068 (901) 465-7359 Fax: (901) 465-7363 Superintendent: Jeannette Birge	Mountain View Youth Development Center Department of Children's Service 809 Peal Lane Dandridge, Tennessee 37725 (423) 397-0174 Fax: (423) 397-0738 Superintendent: Gary Morris
Tennessee Preparatory School ** Department of Children's Services 1200 Foster Avenue Nashville, Tennessee 37243-0385 (615) 741-4018 Fax: (615) Superintendent: Butch Garrett	

* Denotes programs for girls

** Denotes programs for girls and boys

Send Comments to : Department of Children's Services

Services Offered by the Tennessee Commission on Children and Youth

Tennessee Commission on Children and Youth

The objectives of the Tennessee Commission on Children and Youth are performed through seven program areas:

1. *Advocacy*: TCCY provides leadership for advocacy activities on behalf of children and families.
2. *Juvenile Justice*: TCCY is the state advisory group responsible for implementing the provisions of the Juvenile Justice and Delinquency Prevention (JJDP) Act in Tennessee.
3. *Ombudsman Program*: The TCCY Ombudsman staff serve as neutral reviewers to respond to questions, concerns, or complaints regarding children in state custody.
4. *Evaluation of Services for Children*: TCCY conducts targeted evaluations and is responsible for the Children's Program Outcome Review Team (C-PORT) evaluation and the Impact Study. C-PORT collects, analyzes, and reports essential information about the population of children in state custody and their families. The Impact Study utilizes an intensive case review approach to assess the impact of managed care on the delivery of TennCare/Medicaid services to children, with a special focus on children with serious emotional disturbances.
5. *Regional Councils*: TCCY staffs and coordinates nine regional councils that provide organizational structure for statewide networking on behalf of children and families.
6. *Information Dissemination*: TCCY regularly produces and distributes various publications, newsletters and reports which disseminate information on children's issues.
7. *Teenage Pregnancy*: TCCY administers state funds directed toward teenage pregnancy prevention and teen parenting.

This agency may be reached by calling 615/741-6239.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF TENNCARE
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

DATE: NOVEMBER 15, 1999

TO: TennCare MCOs & BHOs

TSOP: 036
Addendum 3

FROM: John F. Tighe
Deputy Commissioner
Department of Finance and Administration

SUBJECT: EPSDT Screening Requirements

The Social Security Act (The Act), as amended by OBRA 89, requires that under the EPSDT benefit, state Medicaid programs must provide for screenings, including vision, hearing, and dental screenings, at intervals which meet reasonable standards of medical and dental practice. These standards are to be established after consultation with recognized medical and dental organizations involved in child health care. The Bureau also takes into consideration HCFA requirements, guidelines established by the CDC, guidelines established by the Tennessee Department of Health, and legislative requirements imposed by the Tennessee General Assembly. Medically necessary treatment, including vision, hearing, and dental services, shall be provided when needed. The Act also requires that any service which is permitted to be covered under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in Tennessee's State Medicaid plan.

Per the TennCare/MCO/BHO contracts, MCOs and BHOs are required to furnish EPSDT screenings, diagnosis, and treatments to all TennCare children under the age of 21. Contractors may not impose prior authorization requirements on periodic screens conducted by the primary care provider, and you must provide all medically necessary, TennCare-covered services regardless of whether the need for such services was identified by a provider whose services had received prior authorization from you or by an in-network provider.

Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to enrollees may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity. **However,** if a service is medically necessary, it must be provided by the MCO/BHO without regard to tentative service benefits limits. Whenever an MCO or BHO states that there is a tentative limit on EPSDT services, enrollees and providers must be told that if medical necessity can be shown, such limit(s) can be waived. The criteria set forth in this TSOP must be forwarded to your provider network to ensure that each child's needs are met.

Screening Requirements

The Bureau of TennCare has adopted the periodicity schedule recommended by the American Academy of Pediatrics for Preventive Pediatric Health Care[1]. Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Physicians (AAFP). As these schedules are reviewed, updated, and revised, the Bureau of TennCare will inform MCOs/BHOs of any changes that may be different from those published. MCOs/BHOs will then need to inform their provider network of any changes.

MCOs/BHOs must provide to eligible EPSDT enrollees who request it, screening services (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but not limited to:

- Comprehensive health and developmental history (including assessment of both physical and mental health development and dietary practices).
- Comprehensive unclothed physical examination (the child's physical growth shall be compared against that considered normal for the child's age).
- Laboratory tests (including blood level assessment appropriate to age and risk).
- Vision testing, to be age appropriate, including diagnosis and treatment for defects in vision, including eyeglasses.
- Hearing testing, to be age appropriate, including diagnosis and treatment for defects in hearing, including hearing aids.
- Appropriate laboratory testing (see below).
- Appropriate immunizations (see below).

- Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. This referral for services is for preventive dental care and screening in accordance with the dental periodicity schedule. At a minimum, to include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services shall be performed by or under the supervision of dentists. Dental services may not be limited to emergencies.

- Health education including anticipatory guidance, i.e., counseling to both parent and child to "assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy life style and practices as well as accident and disease prevention." (HCFA State Medicaid Manual Section 5123.2[E])

The medical screen shall be consistent with HCFA minimum standards. HCFA currently requires at least the following, as medically appropriate: anemia test, sickle cell testing, and tuberculin test. In addition to these, the child's age, sex and health history, clinical systems and exposure to disease can make additional tests necessary, such as urine screening, pinworm slides, urine cultures, serological tests, drug dependence screening, stool specimens for parasite and ova, blood and HIV screening.

The medical screen is also to include appropriate childhood immunizations as recommended by the Center for Disease Control's (CDC) Advisory Committee on Immunization Practices. Currently, EPSDT must cover diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, varicella zoster (for chicken pox), and hemophilus b conjugate (Hib) vaccines. Immunizations that may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time.

A child below the age of six (6) shall also be tested for lead blood poisoning in accordance with current CDC and/or American Academy of Pediatrics recommendations. Children who test high (consistent with CDC measures) and children who are deemed to be "high risk" as a result of the verbal risk assessment must receive follow up consistent with current CDC, and/or American Academy of Pediatrics recommendations.

Screening Service Content

A. Comprehensive Health and Developmental History

This information should be obtained from the parent or other responsible adult who is familiar with the child's history and includes an assessment of both physical and mental health developments. Coupled with the physical exam, this includes:

1. Developmental Assessment

This includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and

cultural background. Screening for developmental assessment is a part of every routine initial and periodic examination.

Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process. You may build the two aspects into the program so that fewer referrals are made for additional developmental assessment.

a. Approach: There is no universal list of dimensions of development for the different age ranges of childhood and adolescence. In younger children, assess at least the following elements:

- Gross motor development, focusing on strength, balance, locomotion;
- Fine motor development, focusing on eye-hand coordination;
- Communication skills or language development, focusing on expression, comprehension, and speech articulation;
- Self-help and self-care skills;
- Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and
- Cognitive skills, focusing on problem solving or reasoning.

As the child grows through school age, focus screens on visual-motor integration, visual-spacial organization; visual sequential memory, attention skills, auditory processing skills, and auditory sequential memory. Most school systems provide routines and resources for developmental screening.

For adolescents, the orientation should encompass such areas of special concern as the potential presence of learning disabilities, peer relations, psychological/psychiatric problems, and vocational skills.

b. Procedures: No list of specified tests and instruments is prescribed for identifying developmental problems because of the large number of such instruments, development of new approaches, the number of children and the complexity of developmental problems which occur, and to avoid the connotation that only certain tests or instruments satisfy Federal requirements. However, the following principles must be considered:

- Acquire information on the child's usual functioning, as reported by the child, parent, teacher, health professional, or other familiar person.
- In screening for developmental assessment, the examiner incorporates and reviews this information in conjunction with other information gathered during the physical examination and makes the objective professional judgment whether the child is in the expected range. Review developmental progress, not

in isolation, but as a component of overall health and well being, given the child's age and culture.

- Developmental assessment should be culturally sensitive and valid. Do not dismiss or excuse improperly potential problems on grounds of culturally appropriate behavior. Do not initiate referrals for factors associated with cultural heritage.
- Screens should not result in a label or premature diagnosis of a child. Providers should report only that a condition was referred or that a type of diagnostic or treatment service is needed. Results of initial screening should not be accepted as conclusions and do not represent a diagnosis.
- Refer to appropriate child development resources for additional assessment, diagnosis, treatment or follow-up when concerns or questions remain after the screening process.

2. Assessment of Nutritional Status

This is accomplished in the basic examination through:

- Questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets which are deficient or excessive in one or more nutrients.
- A complete physical examination including an oral dental examination. Pay special attention to such general features as pallor, apathy, and irritability.
- Accurate measurements of height and weight, which are among the most important indices of nutritional status.
- A laboratory test to screen for iron deficiency. HCFA and PHS recommend that the erythrocyte protoporphyrin (EP) test be utilized when possible for children ages 1-5. Where the EP test is not available, use hemoglobin concentration or hematocrit.
- If feasible, screen children over 1 year of age for serum cholesterol determination, especially those with a family history of heart disease and/or hypertension and stroke.

If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated, including:

- Family, socioeconomic or community factors,
- Determining quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs),
- Further physical and laboratory examinations, and
- Preventive, treatment and follow-up services, including dietary counseling and nutrition education.

B. Comprehensive Unclothed Physical Examination

Which includes the following:

- Physical Growth: Record and compare the child's height and weight with those considered normal for that age. In the first year of life, head circumference measurements are important. Use a graphic recording sheet to chart height and weight over time.
- Unclothed Physical Inspection: Check the general appearance of the child to determine overall health status. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

C. Appropriate Immunizations[2]

Assess whether the child has been immunized against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b conjugate (Hib), Hepatitis B, and varicella zoster (chickenpox); and whatever booster shots are needed. The child's immunization record should be available to the provider.

Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP). These recommendations will be used to determine when Federal Financial Participation (FFP) is not available for single antigen vaccines (unless a combined antigen was medically contraindicated).

D. Appropriate Laboratory Tests

Identify as statewide screening requirements the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups. Examples of some of the tests to be considered as part of the statewide screening requirement are hematocrit or hemoglobin screening, urinalysis, TB skin testing, STD screening, and cholesterol screening. With the exception of lead toxicity screening, physicians providing screening services under EPSDT program use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed. Lead toxicity screening must be performed as indicated below.

(1) Lead Toxicity Screening:

All children are considered at risk and must be screened for lead poisoning. HCFA requires the use of the blood lead test when screening children for lead poisoning. The EP test is no longer acceptable as a screening test for lead poisoning. Physicians should use each office visit as an opportunity for anticipatory guidance and risk assessment for lead poisoning.

❖Risk Assessment: All children from 6 to 72 months of age are considered at risk and must be screened. Beginning at 6 months of age and at each visit thereafter, the provider must discuss with the child's parent or guardian, childhood lead poisoning interventions and assess the child's risk for exposure. Questions should be asked that aid the physician in determining exposure to lead poisoning in the child's home environment, day care, preschool or babysitter's home, contact with those adults who may work with lead (ex: construction or welding), location to factories involved with lead, etc.

❖Determining Risk: Risk is determined from the response to the questions that Tennessee requires for verbal risk assessment[3]. If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure, but must receive blood lead screening by blood lead test at 12 months of age and 24 months of age.

If the answer to any question is positive, a child is considered high risk for high doses of lead exposure. A blood lead test must be obtained at the time a child is determined to be high risk.

Subsequent verbal risk assessments can change a child's risk category. If as the result of a verbal risk assessment a previously low risk child is recategorized as high risk, that child must be given a blood lead test.

❖Screening Blood Tests: The term "screening blood tests" refers to blood tests for children who have not previously been tested for lead with a blood test or who have been previously tested and found not to have an elevated blood lead level. If a child is determined by the verbal risk assessment to be at:

(1) Low Risk: A screening blood lead level is required at 12 months of age and a second blood lead test at 24 months of age.

(2) High Risk: A blood lead test is required when a child is identified as being high risk, beginning at six (6) months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter (µg/dL), a screening blood lead test is required at every prescribed interval in TennCare's EPSDT periodicity schedule through 72 months of age,

Unless the child has already received a blood lead test within the last six (6) months of the periodic visit. A blood lead test result equal to or greater than 10 µg/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

If a child between the ages of 24 months and 72 months has not received a screening blood lead test, then that child must receive it immediately, regardless of being determined at low or high risk.

❖Diagnosis, Treatment, and Follow-up: If a child is found to have a blood lead levels equal to or greater than 10 ug/dL, providers are to use their professional judgment, with reference to CDC guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated.

❖Coordination With Other Agencies: MCOs/BHOs shall work with the Bureau and WIC, Head Start, and other public and private resources to aid in eliminating duplicate testing and ensure comprehensive diagnosis and treatment. Also, public health agencies' childhood lead poisoning prevention programs may be available. These agencies may have authority and ability to investigate a lead-poisoned child's environment and to require remediation.

(2) Anemia Test:

The most easily administered test for anemia is a microhematocrit determination from venous blood or a fingerstick.

(3) Sickle Cell Test:

Diagnosis for sickle cell trait may be done with sickle cell preparation or a hemoglobin solubility test. If a child has been properly tested for sickle cell disease, the test need not be repeated.

(4) Tuberculin Test:

Give a tuberculin test to every child who has not received one within a year.

(5) Others:

In addition to the tests above, there are several other tests to consider. An individual's age, sex, health history, clinical symptoms and exposure determine their appropriateness to disease. These include a urine screening, pinworm slide, urine culture (for girls), serological test, drug dependency screening, stool specimen for parasites, ova, blood, and HIV screening.

E. Health Education

Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives providers

the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

F. Vision and Hearing Screens

Vision and hearing screens are subject to their own periodicity schedules. However, where the periodicity schedules coincide with the schedule for screening services, MCOs/BHOs may include vision and hearing screens as a part of the required minimum screening services.

1. Appropriate Vision Screen[4]: An age-appropriate vision assessment must be administered. Consultation by ophthalmologists and optometrists can help determine the type of procedures to use and the criteria for determining when a child is referred for diagnostic examination.

Ocular alignment and visual acuity once in the 3-6 year old age range. These procedures should be conducted at the first visit during which the patient is cooperative. Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 m, or Random Dot E Sterotest at 40 cm (630 secs of are).

Visual acuity should be tested once in each of the following age ranges: 10-13 years old and 14-18 years old. Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling E, HOTV, Picture Tests, Allen Figures, or LH Tests.

Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather waiting until the next scheduled well child visit.

2. Appropriate Hearing Screen[5]: An age-appropriate hearing assessment must be administered. Obtain consultation and suitable procedures for screening and methods of administering them from audiologists, or from the State Health Department or Education Department.

Newborn hearing screening is recommended for all newborns, and are most likely to occur in hospitals with the results reported to the primary care provider. Currently (1999), not all hospitals in the state have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAF) with thresholds of 30 dB HL.

An objective hearing screening test should be done once in each of the following age ranges: 3-6 years old, 10-13 years old, and 14-18 years old. Screening should be conducted at the first visit during which the patient is cooperative during the above listed intervals. Acceptable methods of objective hearing screening include conventional audiometry, hand-held audiometry, or conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000Hz).

Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather waiting until the next scheduled well child visit.

G. Dental Screening Services[6]:

Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the established periodicity schedules and at other intervals as medically necessary. An eligible child shall be referred to a dentist beginning at the age 3, or earlier if determined to be medically necessary.

Especially in older children, the periodicity schedule for dental examinations is not governed by the schedule for medical examinations. Dental examinations of older children should occur with greater frequency than is the case with physical examinations. The referral must be for an encounter with a dentist, or a professional dental hygienist under the supervision of a dentist, for diagnosis and treatment. However, where any screening, even as early as the neonatal examination, indicates that dental services are needed at an earlier age, the needed dental services are to be provided.

The requirement of a direct referral to a dentist can be met in settings other than a dentist's office. The necessary element is that a dentist or other dental professional under the supervision of a dentist examines the child. In an area where dentists are scarce or not easy to reach, dental examinations in a clinic or group setting may make the service more appealing to enrollees while meeting the dental periodicity schedule. If continuing care providers have dentists on their staff, the direct referral to a dentist requirement is met. Dental paraprofessionals under direct supervision of a dentist may perform routine services when in compliance with State of Tennessee practice acts.

[1]See Attachment A
[2]See Attachment B
[3]See Attachment C
[4]See Attachment D
[5]See Attachment E
[6]See Attachment F

TennCare Authority:

42 U.S.C. §§ 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)
42 C.F.R. § 440.230
42 C.F.R. § 441, Subpart B
HCFA's State Medicaid Manual
TennCare Rules and Regulation 1200-13-12-.04(1)(w)
TennCare/MCO Contract Section 2-3.a.1.; Section 4-8.
TennCare/BHO Contract Section 2.6.1.; Section 5.3.3.1.

TennCare Contact Person:

Regarding -

Medical Issues:	Karen Oldham, M.D.	(615) 741-0213
Quality of Services:	Ken Okolo	(615) 741-0192
Policy:	Melvin Everette	(615) 741-0221
Contract Compliance:	Jack Welch	(615) 532-6743
EPSDT Coordinator:	Kasi Tiller	(615) 532-6089

draft084c:a.9312

ATTACHMENT A

PERIODICITY SCHEDULE FOR EPSDT CHECK-UPS/SCREENS

ATTACHMENT A

PERIODICITY SCHEDULE FOR EPSDT CHECK-UPS/SCREENS

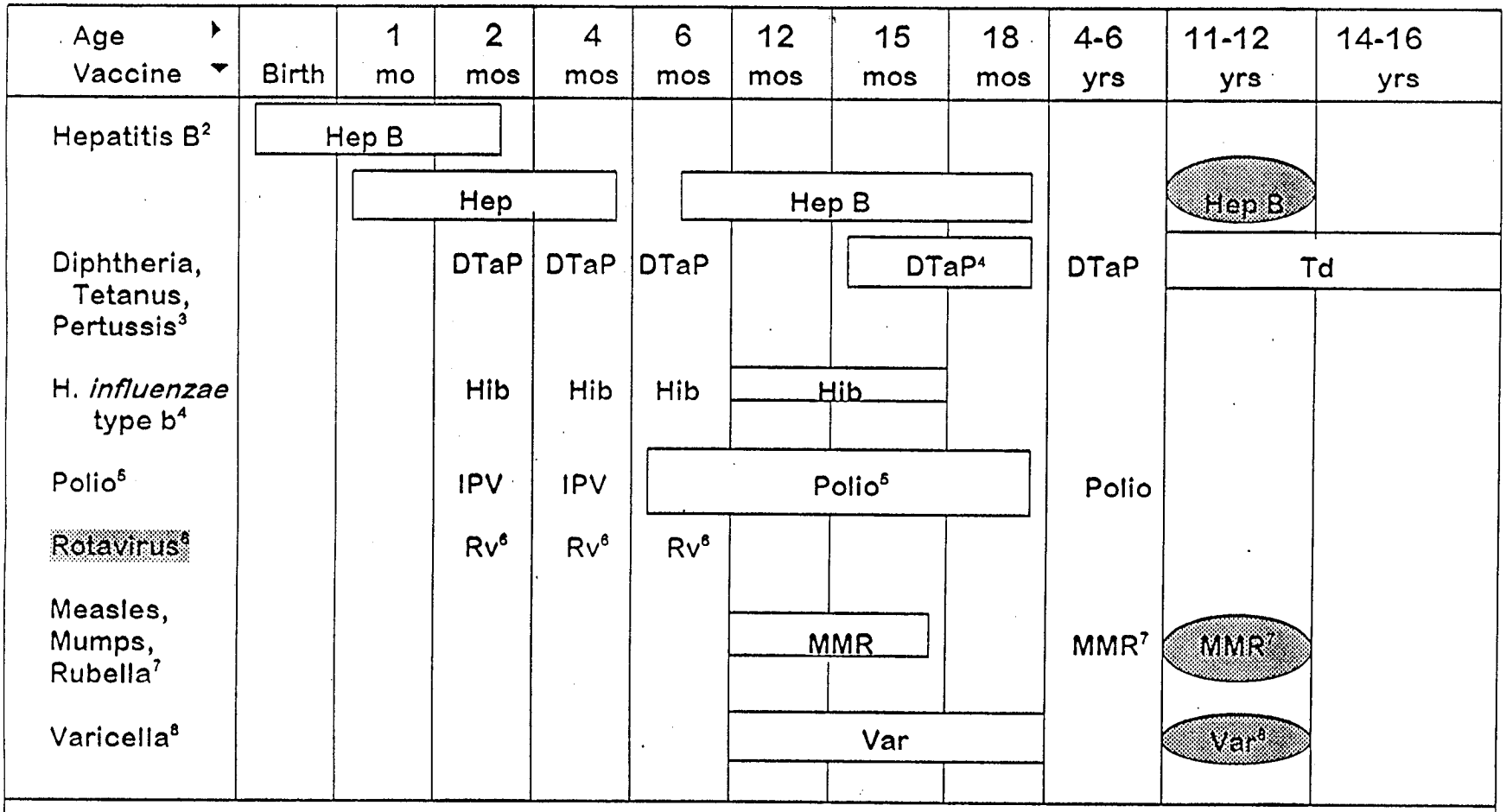
At Birth
2-4 days of age
1 month old
2 months old
4 months old
6 months old
9 months old
15 months old
18 months old
24 months old
3 years old
4 years old
5 years old
6 years old
8 years old
10 years old
11 years old
12 years old
13 years old
14 years old
15 years old
16 years old
17 years old
18 years old
19 years old
20 years old

APPENDIX B

IMMUNIZATION SCHEDULE

Recommended Childhood Immunization Schedule
United States, January – December 1999

Vaccines[1] are listed under routine recommended ages. Bars indicate range of acceptable ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.



Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Phys. (AAFP)

[1] This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combinations are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2] *Infants born to HBsAg-negative mothers* should receive the 2nd dose of hepatitis B vaccine at least 1 month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers *should receive hepatitis B vaccine and 0.5 ml hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1 – 2 months of age and the 3rd dose at 6 months of age.*

Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age). All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of HBV infection.

[3] DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the immunization series, including completion of the series in children who have received 1 or more doses of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose (DTP or DTaP) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and if the child is unlikely to return at ages 15 – 18 months. Td (tetanus and diphtheria toxoids) is recommended at 11 – 12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

[4] Three (3) *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB and COMPAX [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4, or 6 months of age, unless FDA-approved for these ages.

[5] Two (2) poliovirus vaccines are currently licensed in the United States: inactivated poliovirus vaccine (IVP) and oral poliovirus vaccine (OPV). The ACIP, AAP, and AAFP now recommend that the first two (2) doses of poliovirus vaccine should be IPV. The ACIP continues to recommend a sequential schedule of poliovirus vaccine should be IPV administered at ages 2 and 4 months, followed by 2 doses of OPV at 12 – 18 months and 4 – 6 years. Use of IPV for all doses also is acceptable and is recommended for immunocomprised persons and their household contacts. OPV is no longer recommended for the first two (2) doses of the schedule and is acceptable only for special circumstances such as: children of parents who do not accept the recommended number of injections, late initiation of immunization which would require an unacceptable number of injections, and imminent travel to polio-endemic areas. OPV remains the vaccine of choice for mass immunization campaigns to control outbreaks due to wild poliovirus.

[6] Rotavirus (Rv) is shaded to indicate: 1) health care providers may require time and resources to incorporate this new vaccine into practice; and 2) the AAFP feels the decision to use rotavirus vaccine should be made by the parent or guardian in consultation with their physician or other health care provider. The first dose of Rv vaccine should not be administered before 6 weeks of age, and the minimum interval between doses is 3 weeks. The Rv vaccine should not be initiated at 7 months of age or older, and all doses should be completed by the first birthday.

[7] The 2nd dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at 4 – 6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should be complete the schedule by the 11 – to 12-year-old visit.

[8] Varicella vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e., those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or over should receive 2 doses, given at least 4 weeks apart,

ATTACHMENT C

LEAD RISK ASSESSMENT

ATTACHMENT C

Lead Risk Assessment Questions

1. Does your child live in or regularly visit a home with peeling or chipping paint built before 1960? (This could include a day care center, home of a baby sitter, or relative.)

2. Does your child live in a house built before 1978 with recent, or ongoing, or planned renovations or remodeling?

3. Does your child frequently come in contact with an adult who works with lead? (Examples: construction, welding, pottery, or other trades or hobbies that utilize lead.)

4. Does your home contain any plastic or vinyl mini blinds?

5. Have you been told your child has low iron?

6. Have any of your children or their playmates had lead poisoning?

7. Have you seen your child eating paint chips, crayons, soil or dirt?

8. Does your child live near a lead smelter, battery recycling plant or other industry that is likely to release lead? (Give examples in the child's community.)

9. Do you give your child any home or folk remedies, which may contain lead? (Give examples such as Moonshine, Azarcon, Greta, and Paylooah.)

10. Does your child live within 80 feet of a heavily traveled road or on a heavily traveled street?

11. Does your home's plumbing have lead pipes or copper with lead solder joints?

12. Does you family use pottery ware or leaded crystal for cooking, eating, or drinking?

Determining Risk Factors

Risk is determined from the response to the questions on the verbal risk assessment.

- If all the answers are negative a child is considered **low risk.** Low risk children continue to be assessed for risk from 6 months to 60 months of age. For low risk children residing in the designated high risk counties, a blood lead level is required at 12 months and a second blood lead level at 24 months during routine well-child exam.

The following counties have identified as being high-risk areas for childhood lead poisoning:

Bedford	Giles	Putnam
Bradley	Hamilton	Rutherford
Cumberland	Knox	Shelby
Davidson	Madison	Sullivan
Fayette	Maury	Sumner
Gibson	Montgomery	Tipton

*As risk factors change over time, so may the targeted counties. Up dates will be issued as appropriate.

- If the answer to any question is positive, a child is considered high risk. A blood level (BLL) should be obtained on any child identified to be high-risk during the screening exams a six (6), twelve (12), twenty-four (24), thirty-six (36), and sixty (60) months of age. Once identified as high-risk, a child's BLL should be followed at least to the age of 24 months. If the BLL is less than 10 µg/dL at 24 months, then no further screenings are required unless that child moves to another house prior to 72 months of age, or other previous negative risk factors become positive.

- All elevated blood levels must be confirmed by venous blood sampling. The time between the initial capillary screening and venous confirmation must be based on the criteria below.

If the result of the screening test (µg/dL) is:	Perform diagnostic test on venous blood within:
10 - 19	3 months
20 - 44	1 month - 1 week*
45 - 59	48 hours
60 - 69	24 hours
70	immediately as an emergency lab test

*The higher the screening BLL, the more urgent the need for a confirmation test.

ATTACHMENT D

VISION SCREENING

ATTACHMENT D

VISION SCREENING

Recommendations for Subjective Vision Screening	Recommendations for Objective Vision Screening
Newborn	Eye exam: red reflex, corneal inspection
2 - 4 days	Eye exam: red reflex, corneal inspection
By one month Parental perception of vision	Eye exam: red reflex, corneal inspection Fixes on face, follows with eyes
2 months Parental perception of vision	Eye exam: red reflex, corneal inspection Fixes on face, follows with eyes
3 months Parental perception of vision	Eye exam - fixes and follows each eye
4 months Parental perception of vision	Eye exam - fixes and follows each eye
6 months Parental perception of vision	Eye exam - fixes and follows each eye
9 months Parental perception of vision	Eye exam - fixes and follows each eye
12 months Parental perception of vision	Eye exam - fixes and follows each eye
15 months Parental perception of vision Can see small objects	Eye exam Can see small objects
18 months Parental perception of vision Can see small objects	Eye exam Can see small objects
24 months Parental perception of vision Can see small objects	Eye exam Can see small objects
3 years Parental perception of vision Can see small objects	Eye exam - Ocular alignment, visual acuity (optional) Can see small objects

4 years Parental perception of vision	Eye exam - Ocular alignment, visual acuity (if not done at 3 years)
5 years Parental perception of vision	Eye exam - Ocular alignment, visual acuity (if not done at 3 or 4 years)
6 years Parental perception of vision	Eye exam - Ocular alignment, visual acuity (if not done at 3, 4, or 5 years)
7 years Parental and patient perception of vision	Eye exam
8 years Parental and patient perception of vision	Eye exam
9 years Parental and patient perception of vision	Eye exam
10 years Parental and patient perception of vision	Eye exam - Visual Acuity
11 years Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 10 years)
12 years Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 10 or 11 years)
13 years Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 10, 11, or 12 years)
14 years Parental and patient perception of vision	Eye exam - Visual Acuity
15 years Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 14 years)
16 years Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 14 or 15 years)
17 years Parental and patient perception of vision	Eye exam - Visual Acuity(if not done at 14, 15, or 16 years)
18 years Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 14, 15, 16, or 17 years)

19 years		
	Parental and patient perception of vision	Eye exam
20 years		
	Parental and patient perception of vision	Eye exam
21 years		
	Parental and patient perception of vision	Eye exam

ATTACHMENT E

HEARING SCREENING

ATTACHMENT E

HEARING SCREENING

Recommendations for Subjective Hearing Screening	Recommendations for Objective Hearing Screening
Newborn Parental perception of hearing Family history Wakes to loud noises Head turning to voice/noise	ABR or OAE, if performed in hospital Observational screening with noisemaker (optional)
2 - 4 days Parental perception of hearing Family history Response to voice and noise - parental report	ABR or OAE, if performed in hospital Observational screening with noisemaker (optional)
By 1 month Parental perception of hearing Family history (unless previously recorded) Response to voice and noise - parental report	Ear exam Observational screening with noisemaker (optional)
2 months Parental perception of hearing Family history (unless previously recorded) Response to voice and noise - parental report	Ear exam Observational screening with noisemaker (optional)
3 months Parental perception of hearing Family history (unless previously recorded) Response to voice and noise - parental report	Ear exam Observational screening with noisemaker (optional)
4 months Parental perception of hearing Recognizes parent's voice - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
5 months Parental perception of hearing Recognizes parent's voice - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
6 months Parental perception of hearing Turns to sound - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)

9 months	
Parental perception of hearing	Ear exam
Response to voice and noise - parental report	Observational screening with noisemaker (optional)
Family history (unless previously recorded)	
12 months	
Parental perception of hearing	Ear exam
Response to voice and noise - parental report	Observational screening with noisemaker (optional)
Family history (unless previously recorded)	
15 months	
Parental perception of hearing	Ear exam
Response to voice and noise - parental report	Observational screening with noisemaker (optional)
Family history (unless previously recorded)	
18 months	
Parental perception of hearing	Ear exam
Response to voice and noise - parental report	Observational screening with noisemaker (optional)
Family history (unless previously recorded)	
24 months	
Parental perception of hearing	Ear exam
Response to voice and noise - parental report	Observational screening with noisemaker (optional)
Family history (unless previously recorded)	
3 years	
Parental perception of hearing	Ear exam Hearing Screen (optional) Observational screening with noisemaker (optional)
4 years	
Parental perception of hearing	Ear exam Hearing Screen (if not done at 3 years)
5 years	
Parental perception of hearing	Ear exam Hearing Screen (if not done at 3 or 4 years)
6 years	
Parental perception of hearing	Ear exam Hearing Screen (if not done at 3, 4 or 5 years)
7 years	
Parental and patient perception of hearing	Ear exam Hearing Screen

8 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7 years)
9 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7 or 8 years)
10 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, or 9 years)
11 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, 9, or 10 years)
12 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, 9, 10, or 11 years)
13 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, 9, 10, 11, or 12 years)
14 years Parental and patient perception of hearing	Ear exam Hearing Screen
15 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14 years)
16 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14 or 15 years)
17 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14, 15, or 16 years)
18 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14, 15, 16, or 17 years)

19 years		
	Parental and patient perception of hearing	Ear exam
20 years		
	Parental and patient perception of hearing	Ear exam
21 years		
	Parental and patient perception of hearing	Ear exam

ATTACHMENT F

DENTAL SCREENING

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC DENTAL CARE*

Because each child is unique these Recommendations are designed for the care of children who have no important health problems and are developing normally. These Recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations. The Academy emphasizes the important of very early professional intervention and the continuity of care based on the individualized needs of the child.

Recommended Pediodontic Care — Required by contract beginning at 3 years of age

Age[1]	Infancy 6-12 Mons.	Late Infancy 12-24 Mons.	Preschool 2-6 Years	School-Aged 6-12 Years	Adolescence 12-21 Years
Oral Hygiene[2] Counseling	Parents/Guardians/ Caregivers	Parents/Guardians/ Caregivers	Child/Parent/ Caregivers	Child/Parent/ Caregivers	Patient
Injury Prevention[3] Counseling	*	*	*	*	*
Dietary Counseling[4]	*	*	*	*	*
Counseling for[5] Non-nutritive Habits	*	*	*	*	*
Fluoride[6] Supplementation	*	*	*	*	*
Assess Oral Growth[7] & Development	*	*	*	*	*
Clinical Oral Exam every 6 mo.	*	*	*	*	*
Prophylaxis and [8] Topical Fluoride Treatment every 6 mo.	*	*	*	*	*
Radiographic[9] Assessment	*	*	*	*	*
Pit & Fissure Sealant			If indicated on primary molars	1st permanent molars as soon as possible after eruption	2nd permanent molars as soon as possible after eruption
Treatment of Dental Disease/Injury	*	*	*	*	*
Assessment and Treatment of Developing Malocclusion			*	*	*
Substance Abuse Counseling				*	*
Assessment and Removal of 3rd molar					*
Referral for Regular and Periodic Dental Care					*
Anticipatory Guidance[10]	*	*	*	*	*

Notes:

1. First exam at the eruption of the first tooth and no later than 12-18 months.
2. Initially, responsibility of parent; as child develops jointly with parents; then when indicated only child.
3. Initially play objects, pacifiers, car seats; then when learning to walk; and finally sports and routine playing.
4. At every appointment discuss the role of refined carbohydrates; frequency of snacking.
5. At first discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before the eruption of the first permanent front teeth.
6. As per AAP/ADA Guidelines and the water source.
7. By clinical examination.
8. Especially for children at high risk for caries and periodontal disease.
9. As per AAPD Radiographic Guidelines.
10. Appropriate discussion and counseling, should be an integral part of each visit for caries.

**American Academy of Pediatric Dentistry, May, 1992.*

Attachment H

Progress Towards EPSDT Targets

Progress Toward EPSDT Targets

	Column A	*Column B*	*Column C*	*Column D*
Year	**HCFA 416 screening per-centage***	**Percentage of required 7 components included in screens****	**Adjusted Periodic Screening Percentage (APSP)*****	**Dental Screening Percentage (DSP)********
FFY 96 (baseline)	39%	56.2%	21.9%	28.2%
FFY 97	45%	55.1%	24.8%	31.1%
FFY 98	39%			30.8%
First Target FFY 99			***Target: 51.9%***	***Target: 38.2%***
FFY 00			• ***If the figure for FFY 99 is < 55, minimum 20 point increase*** • ***If the figure for FFY 99 is > 55, minimum 10 point increase***	• ***Minimum 10 point increase***
FFY 01			***Final Target: 80%***	• ***Minimum 10 point increase***
FFY 02				• ***Minimum 10 point increase***
FFY 03				***Final Target: 80%***

*This percentage is taken from the ratio reported on the HCFA 416 that is filed each year. It is determined according to a formula given us by HCFA, which involves dividing the actual number of screening services provided by the expected number of screening services that should have been provided, given the ages and numbers of children enrolled.

**This percentage is obtained by the QI Unit after conducting an annual statistically valid medical record review of encounters coded as periodic screens.

***This percentage is calculated by multiplying the figure in Column A by the figure in Column B.

****This percentage is calculated by dividing the actual number of dental encounters provided for children aged 3-20 by the expected number of encounters (1 per year) for children in this age group.

Attachment I

Department of Children's Services
EPSDT and Dental Screens Report

EPSDT & Dental Screens Conducted on New Commitments to Custody during Month (Unfiltered Data*)

July (unfiltered) per CORS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	49	22	44.9	9	18.4
East TN	79	28	35.4	16	20.3
Hamilton Co.	20	7	35.0	2	10.0
Knox Co.	40	33	82.5	23	57.5
Mid Cumb.	58	30	51.7	12	20.7
NE	40	18	45.0	10	25.0
NW	21	21	100.0	15	71.4
Shelby Co.	47	2	4.3	1	2.1
S Central	29	23	79.3	15	51.7
SE (TNKIDS)	27	25	92.6	15	55.6
SW	35	28	80.0	23	65.7
Upper Cumb.	34	24	70.6	9	26.5
Total	**479**	**261**	**54.5**	**150**	**31.3**

August (unfiltered) per CORS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	74	4	5.4	3	4.1
East TN	76	15	19.7	7	9.2
Hamilton Co.	13	6	46.2	0	0.0
Knox Co.	25	17	68.0	10	40.0
Mid Cumb.	77	27	35.1	9	11.7
NE	45	7	15.6	3	6.7
NW	36	22	61.1	13	36.1
Shelby Co.	51	4	7.8	2	3.9
S Central	43	19	44.2	9	20.9
SE (TNKIDS)	30	23	76.7	10	33.3
SW	40	19	47.5	17	42.5
Upper Cumb.	48	6	12.5	2	4.2
Total	**558**	**169**	**30.3**	**85**	**15.2**

September (unfiltered) per CORS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	74	5	6.8	3	4.1
East TN	68	7	10.3	3	4.4
Hamilton Co.	6	2	33.3	1	16.7
Knox Co.	32	16	50.0	9	28.1
Mid Cumb.	71	12	16.9	5	7.0
NE	35	6	17.1	2	5.7
NW	26	2	7.7	1	3.8
Shelby Co.	65	2	3.1	0	0.0
S Central	38	14	36.8	9	23.7
SE	n/a	n/a	n/a	n/a	n/a
SW	36	8	22.2	4	11.1
Upper Cumb.	20	4	20.0	2	10.0
Total	**471**	**78**	**16.6**	**39**	**8.3**

September (unfiltered) per TNKIDS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	70	5	7.1	2	2.9
East TN	61	9	14.8	3	4.9
Hamilton Co.	20	0	0.0	0	0.0
Knox Co.	42	12	28.6	4	9.5
Mid Cumb.	41	8	19.5	1	2.4
NE	35	6	17.1	3	8.6
NW	26	9	34.6	5	19.2
Shelby Co.	55	8	14.5	2	3.6
S Central	40	17	42.5	10	25.0
SE	35	21	60.0	5	14.3
SW	34	4	11.8	2	5.9
Upper Cumb.	23	3	13.0	2	8.7
Total	**482**	**102**	**21.2**	**39**	**8.1**

*Note: Unfiltered data includes all children, regardless of placement status or age. This is how data were reported in past EPSDT reports, and includes children in YDCs, detention, or on runaway status (for health screens) and children under three (for dental screens).

EPSDT & Dental Screens Conducted on New Commitments to Custody during Month (Filtered Data*)

September (filtered) per CORS

Region	Total	With EPSDT Date within time frame**	With EPSDT Date outside specified time	% of Total with EPSDT Date	Children age 3 and over	With Dental Date within time frame	With Dental Date outside specified time	% of age 3+ with Dental
Davidson Co.	49	5	0	10.2%	36	3	0	8.3%
East TN	58	6	0	10.3%	51	2	0	3.9%
Hamilton Co.	4	1	0	25.0%	2	0	0	0.0%
Knox Co.	27	12	0	44.4%	19	6	0	31.6%
Mid Cumb.	63	9	1	15.9%	55	3	1	7.3%
NE	33	5	1	18.2%	28	1	1	7.1%
NW	20	2	0	10.0%	19	1	0	5.3%
Shelby Co.	54	2	0	3.7%	34	0	0	0.0%
S Central	35	13	0	37.1%	30	7	0	23.3%
SE	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SW	31	8	0	25.8%	28	3	1	14.3%
Upper Cumb.	17	3	0	17.6%	14	1	0	7.1%
Total	**391**	**66**	**2**	**17.4%**	**316**	**27**	**3**	**9.5%**

September (filtered) per TNKIDS

Region	Total	With EPSDT Date within time frame	With EPSDT Date outside specified time	% of Total with EPSDT Date	Children age 3 and over	With Dental Date within time frame	With Dental Date outside specified time	% of age 3+ with Dental
Davidson Co.	64	4	1	7.8%	51	2	0	3.9%
East TN	54	7	2	16.7%	51	3	0	5.9%
Hamilton Co.	19	0	0	0.0%	18	0	0	0.0%
Knox Co.	35	5	1	17.1%	23	3	0	13.0%
Mid Cumb.	36	6	1	19.4%	34	0	1	2.9%
NE	33	5	1	18.2%	28	1	2	10.7%
NW	20	8	1	45.0%	19	1	4	26.3%
Shelby Co.	44	8	0	18.2%	28	0	2	7.1%
S Central	37	14	2	43.2%	34	6	2	23.5%
SE	30	16	2	60.0%	27	4	0	14.8%
SW	31	2	2	12.9%	28	0	2	7.1%
Upper Cumb.	21	2	0	9.5%	18	1	0	5.6%
Total	**424**	**77**	**13**	**21.2%**	**359**	**21**	**13**	**9.5%**

* Filtered means that children who were placed in a YDC, detention facility, or on runaway status at end of month were excluded from analyses since exam not covered by TennCare. Also, only children age three and over are included for analyses for dental examinations.

**Time frame refers to the Departmental goal of obtaining health/dental screens within 30 days of custody date, unless child has already had an exam. If the child enters custody having already had a health/dental exam, the time frame is within 1 year of entering custody.

EPSDT & Dental Screens for All Children in Custody at End of Month (Unfiltered Data*)

July (unfiltered) per CORS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	1,254	979	78.1	674	53.7
East TN	1,241	1,141	91.9	1,016	81.9
Hamilton Co.	689	582	84.5	352	51.1
Knox Co.	674	660	97.9	598	88.7
Mid Cumb.	1,384	1,317	95.2	1,065	77.0
NE	853	848	99.4	723	84.8
NW	374	361	96.5	295	78.9
Shelby Co.	1,871	1,436	76.8	1,184	63.3
S Central	758	643	84.8	493	65.0
SE (TNKIDS)	637	533	83.7	149	23.4
SW	908	905	99.7	876	96.5
Upper Cumb.	546	524	96.0	428	78.4
Total	**11,189**	**9,929**	**88.7**	**7,853**	**70.2**

August (unfiltered) per CORS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	1,250	987	79	764	61.1
East TN	1,230	1,090	88.6	963	78.3
Hamilton Co.	649	570	87.8	350	53.9
Knox Co.	685	669	97.7	605	88.3
Mid Cumb.	1,390	1,310	94.2	1,041	74.9
NE	838	835	99.6	712	85.0
NW	384	364	94.8	300	78.1
Shelby Co.	1,844	1,430	77.5	1,198	65.0
S Central	745	637	85.5	490	65.8
SE (TNKIDS)	620	556	89.7	421	67.9
SW	881	879	99.8	854	96.9
Upper Cumb.	545	495	90.8	407	74.7
Total	**11,061**	**9,822**	**88.8**	**8,105**	**73.3**

September (unfiltered) per CORS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	1,242	941	75.8	706	56.8
East TN	1,253	1,068	85.2	929	74.1
Hamilton Co.	640	567	88.6	366	57.2
Knox Co.	685	661	96.5	586	88.7
Mid Cumb.	1,425	1,174	82.4	923	64.8
NE	837	739	88.3	614	73.4
NW	386	347	89.9	291	75.4
Shelby Co.	1,853	1,456	78.6	1,211	65.4
S Central	747	638	85.4	476	63.7
SE	n/a	n/a	n/a	n/a	n/a
SW	868	796	91.7	763	87.9
Upper Cumb.	544	495	91.0	409	75.2
Total	**10,480**	**8,882**	**84.8**	**7,274**	**69.4**

September (unfiltered) per TNKIDS

Region	Total	With EPSDT Date	% of Total with date	With Dental Date	% of Total with Dental
Davidson Co.	1,201	909	75.7	687	57.2
East TN	1,245	1,063	85.4	919	73.8
Hamilton Co.	645	10	1.6	3	0.5
Knox Co.	677	50	7.4	36	5.3
Mid Cumb.	1,351	1,152	85.3	900	66.6
NE	809	711	87.9	596	73.7
NW	391	359	91.8	301	77.0
Shelby Co.	1,812	1,441	79.5	1,195	65.9
S Central	741	636	85.8	480	64.8
SE	620	574	92.6	431	69.5
SW	827	560	67.7	458	55.4
Upper Cumb.	533	475	89.1	393	73.7
Total	**10,852**	**7,940**	**73.2**	**6,399**	**59.0**

*Note: Unfiltered data includes all children, regardless of placement status or age. This is how data were reported in past EPSDT reports, and includes children in YDCs, detention, or on runaway status (for health screens) and children under three (for dental screens).

EPSDT & Dental Screens for All Children in Custody at End of Month (Filtered Data*)

September (filtered) per CORS

Region	Total	With EPSDT Date within time frame**	With EPSDT Date outside specified time	% of Total with EPSDT Date	Children age 3 and over	With Dental Date within time frame	With Dental Date outside specified time	% of age 3+ with Dental
Davidson Co.	999	127	752	88.0%	803	33	580	76.3%
East TN	1,076	276	679	88.8%	902	121	628	83.0%
Hamilton Co.	512	78	403	93.9%	394	19	262	71.3%
Knox Co.	589	136	437	97.3%	439	69	350	95.4%
Mid Cumb.	1,301	262	836	84.4%	1,068	55	722	72.8%
NE	749	139	542	90.9%	559	52	419	84.3%
NW	345	97	224	93.0%	288	37	212	86.5%
Shelby Co.	1,712	96	1,320	82.7%	1,076	33	779	75.5%
S Central	675	144	454	88.6%	546	66	324	71.4%
SE	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SW	799	154	583	92.2%	601	67	462	88.0%
Upper Cumb.	493	107	349	92.5%	378	24	297	84.9%
Total	**9,250**	**1,616**	**6,579**	**88.6%**	**7,054**	**576**	**5,035**	**79.5%**

September (filtered) per TNKIDS

Region	Total	With EPSDT Date within time frame	With EPSDT Date outside specified time	% of Total with EPSDT Date	Children age 3 and over	With Dental Date within time frame	With Dental Date outside specified time	% of age 3+ with Dental
Davidson Co.	948	114	703	86.2%	761	22	552	75.4%
East TN	993	243	634	88.3%	827	103	566	80.9%
Hamilton Co.	512	1	8	1.8%	396	0	2	0.5%
Knox Co.	556	6	28	6.1%	394	4	14	4.6%
Mid Cumb.	1,188	245	796	87.6%	964	48	671	74.6%
NE	682	125	488	89.9%	500	41	378	83.8%
NW	341	93	230	94.7%	281	32	216	88.3%
Shelby Co.	1,615	97	1,263	84.2%	978	27	736	78.0%
S Central	629	129	429	88.7%	501	58	306	72.7%
SE	566	138	395	94.2%	429	30	291	74.8%
SW	739	109	389	67.4%	556	40	259	53.8%
Upper Cumb.	462	90	328	90.5%	355	27	264	82.0%
Total	**9,231**	**1,390**	**5,691**	**76.7%**	**6,942**	**432**	**4,255**	**67.5%**

* Filtered means that children who were placed in a YDC, detention facility, or on runaway status at end of month were excluded from analyses since exam not covered by TennCare. Also, only children age three and over are included for analyses for dental examinations.

**Time frame refers to the Departmental goal of obtaining health/dental screens within 30 days of custody date, unless child has already had an exam. If the child enters custody having already had a health/dental exam, the time frame is within 1 year of entering custody.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B. CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTN P. by his next friend, LINDA C. BAYLIS. By her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)
Plaintiffs,	)
vi.	)NO. 3-98-0168)Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)
Defendants.	)

JANUARY 2000 SEMI-ANNUAL PROGRESS REPORT

Pursuant to Paragraph 104 of the Consent Decree entered on March 11, 1998, the state Defendants agreed to file a semi-annual report with this Court and plaintiffs' counsel

through a process lead and facilitated by consultant Paul DeMuro, negotiated a mutually acceptable remedial plan for assuring adequate health services for children in the plaintiff subclass. Accordingly, the parties submit for the Court's approval the attached proposed Remedial Plan for Children in State Custody.

The parties have developed the attached proposed remedial plan based on the structure of the TennCare program in place as of May 11, 2000. It is expressly the understanding and assumption of the parties in submitting this proposal that any subsequent change to that programmatic structure may necessitate modification of this remedial plan. In the event that TennCare undergoes programmatic structural changes, the parties will assess whether related modifications to this remedial plan are made necessary, will work together to develop appropriate modifications, and, if unsuccessful in that effort, will seek appropriate relief from the Court.

Respectfully submitted,

LINDA A. ROSS
Deputy Attorney General
NICK AEMISEGGER
Assistant Attorney General
Health Care Division
Cordell Hull Building, 2nd Floor
425 Fifth Avenue North
Nashville, Tennessee 37243
(615) 741-1771

Counsel for the Defendants

Decree. Thereafter, the parties renewed their negotiations in an attempt to develop a joint plan to be filed with the Court. Despite the parties' best efforts, negotiations eventually broke down, and the defendants unilaterally filed another proposed plan on February 15, 2000, which superceded the earlier plan. In the weeks since, the parties have managed to resolve their remaining differences and have agreed to the terms of the attached plan. The attached plan supercedes the Defendants' Proposed Health Plan for Children in State Custody filed February 15, 2000.

EPSDT OUTREACH AND INFORMING SURVEY

The Bureau of TennCare and its MCO's and BHO's are required to inform all TennCare enrollees under 21 about the availability of and how to access EPSDT services. This should be accomplished in a timely manner, generally within 60 days of the MCO/BHO's receipt of notification of the child's TennCare eligibility. Please attach all documentation that supports your outreach and informing activities regarding EPSDT.

Please include methods of communication

Oral			Written		
Outreach representative	yes_	no_	New member letter	yes_	no_
Provider relations	yes_	no_	Member newsletter	yes_	no_
Public service announcement	yes_	no_	Posters, flyers, brochures	yes_	no_
Community awareness program	yes_	no_	Member handbook annually	yes_	no_
Member services representative	yes_	no_	Returned mail is tracked	yes_	no_

Timeframe for sending new member letter:
Actions taken to address returned mail

Individuals to be informed

Parent/guardian of newly eligible child	yes_	no_	Families in WIC program	yes_	no_
TennCare eligible pregnant women	yes_	no_	Administrator of institution	yes_	no_

Procedures in place to contact members who are: (Please explain)
Blind –
Illiterate-
Deaf-
Non-English speaking-
What is the process in place to monitor the effectiveness of these procedures?

Submit any documentation of coordination with other programs such as:

Head Start	AFDC
Educational systems	Day Care Licensing Agency
WIC	Health department

Internal Tracking System

Internal tracking system is in place?	yes_ no_
Can past due EPSDT services for each member be determined?	yes_ no_
Can pending service due dates be determined?	yes_, no_
What is method used for member notification?	

Please include:
Policy outlining mechanism of documentation of attempts to contact member regarding EPSDT services, and documentation of EPSDT services that are declined
Copies of last 4 member newsletters
Policy for distribution of posters and brochures
BE 10/99

MCO/BHO EPSDT OUTREACH AND INFORMING SURVEY

DOCUMENTATION OF COORDINATION WITH OTHER PROGRAMS SUCH AS:

	HEAD START	EDUCATIONAL SYSTEMS	WIC	AFDC	DAY CARE LICENSING AGENCY	HEALTH DEPT.
ACCESS MED PLUS	X	X	X	X	X	X
BLUE CARE	X	X	X	X	X	X
JOHN DEERE	O	O	X	O	O	X
OMNI	O	X	X	O	O	X
PHP	X	X	X	X	X	X
PRUCARE	X	X	X	X	X	X
TLC	O	O	X	O	O	X
VHP	X	X	X	X	X	X
XANTUS	X	O	X	X	X	X
PREMIER	X	X	N/A	N/A	N/A	X
TBH	X	X	N/A	N/A	N/A	X

INTERNAL TRACKING SYSTEM

	TRACKING SYSTEM IN PLACE	CAN DETERMINE PAST DUE EPSDT SERVICES	CAN DETERMINE PENDING SERVICE DUE DATE	METHOD USED FOR MEMBER NOTIFICATION
ACCESS MED PLUS	X	X	X	X
BLUE CARE	X	X	X	X
JOHN DEERE	X	X	X	X
OMNI	X	X	X	X
PHP	O	O	O	O
PRUCARE	X	X	X	X
TLC	X	X	X	X
VHP	X	X	X	X
XANTUS	X	X	X	X
PREMIER	X	X	X	X
TBH	X	X	X	X

X=submitted documentation
O=documentation not submitted
N/A= not applicable

MCOBHO EPSDT OUTREACH AND INFORMING SURVEY

METHODS OF ORAL COMMUNICATION

	OUTREACH REPRESENTATIVE	PROVIDER RELATIONS	PUBLIC SERVICE ANNOUNCEMENT	COMMUNITY AWARENESS PROGRAM	MEMBER SERVICE REPRESENTATIVE		
ACCESS MED PLUS	X	X	X	X	X		
BLUE CARE	X	X	O	X	X		
J0HN DEERE	O	X	X	O	X		
OMNI	X	X	O	X	X		
PHP	X	X	O	X	X		
PRUCARE	X	X	O	X	X		
TLC	X	X	O	X	X		
VHP	X	O	O	X	X		
XANTUS	X	X	X	X	X		
PREMIER	X	X	O	X	X		
TBH	X	X	O	X	X		

METHODS OF WRITTEN COMMUNICATION

	NEW MEMBER LETTER	MEMBER NEWSLETTER	POSTERS, FLYERS, BROCHURES	MEMBER HANDBOOK ANNUALLY	RETURNED MAIL TRACKED	TIMEFRAME FOR SENDING NEW LETTER	TAKEN TO ADDRESS RETURNED
ACCESS MED PLUS	X	X	X	X	X	X	X
BLUE CARE	X	X	X	X	X	X	X
J0HN DEERE	X	X	X	X	X	X	X
OMNI	O	X	X	X	X	X	X
PHP	X	X	X	X	X	X	X
PRUCARE	X	X	X	X	X	X	X
TLC	X	X	X	X	X	X	X
VHP	X	X	X	X	X	X	X
XANTUS	X	X	X	X	X	X	X
PREMIER	X	X	O	X	X	X	X
TBH	X	X	O	X	X	X	X

X=submitted documentation
O=documentation not submitted
N/A= not applicable

Memorandum

To: Kasi Tiller

From: BHO Quality Oversight Division

Date: 12/29/99

Re: Summary of Tennessee Behavioral Health EPSDT Outreach and Informing Activities

---

TBH has used many different types of oral communication such as outreach representatives, provider relations, community awareness programs and member services representatives in order to provide information to members and the community in general. TBH has facilitated training sessions and workshops for providers statewide, as well as field representatives facilitating regional planning meetings with the providers to discuss needs specific to their region.

Written communication programs for TBH include new member letters, member newsletters, an annual member handbook, and a newly developed system that tracks returned mail. TBH has developed policies and procedures to support this new tracking system.

The parents/guardians of children that are newly eligible receive information about EPSDT when they receive a new member letter as well as a member handbook, which explains the EPSDT process. In addition, administrators of institutions are informed of EPSDT through a copy of the provider manual, which all administrators receive.

TBH coordinates with outside agencies such as Tennessee Voices for Children, TDMHMR Children's Issues Committee, Tennessee Medical Association, the Family Violence and Homeless Shelters in Tennessee and participates in the EPSDT Task Force.

TBH has developed an internal tracking system that will track any complaints, compliments and grievances regarding EPSDT. Furthermore, any past due EPSDT services for each member can be determined through their computer system for members with special behavioral health needs.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER
FROM: CAROL MIONE, RN
DATE: DECEMBER 28, 1999
RE: SUMMARY OF XANTUS EPSDT OUT REACH AND INFORMING ACTIVITIES

Xantus has developed different modes to encourage enrollees to use EPSDT services. Included in their outreach effort is the distribution of 1999 Members Handbook, explaining EPSDT services and timelines, quarterly member newsletters (last mailed Spring 1999 with draft of Fall 1999 reviewed), "Coming Attractions Club" to educate expecting parents in the care of their anticipated arrival and the "Birthday Club" reminding enrollees to get preventive health exams/services. Some of the outreach material provided by Xantus for review was dated 1998 as well as some policies and procedures were not dated or approved and others were only in draft form. All methods of oral and written communication were used, but the only non-English speaking used was Spanish. Procedures were in place for communication with members with special needs, except no documentation revealed any form of communication available for illiterate enrollees. Hedis 3.0 software was implemented this year for an internal tracking mechanism to assist the Quality Improvement department to identify specific preventive services rendered, due and past due. A draft copy of an "EPSDT Services Provided" form has been developed and once approved will be distributed to all providers in an effort improve EPSDT compliance among providers. A member of the Quality Improvement department participates on EPSDT Davidson County Task Force and the TennCareShelter Enrollment Project.

Xantus is striving to improve all aspects of EPSDT by identifying the population in need, developing a successful outreach program, and implementing a new internal tracking system. Xantus is also working with other MCOs and health care delivery systems to achieve a higher rate of compliance, as well as mirror the efforts of the Davidson County EPSDT Task Force throughout the state.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: CAROL MIONE, RN

DATE: 12/28/99

RE: SUMMARY OF PERFERRED HEALTH PARTNERSHIP OF TENNESSEE, INC. (PHP) EPSDT OUTREACH AND INFORMING ACTIVITIES

In January 1999, PHP delegated all quality improvement of its EPSDT functions to Tennessee Health Partnership (THP) following a downsizing. PHP is in the process of refining the oversight of these delegated functions. The Academy of Pediatrics preventive guidelines for children and contractually required EPSDT guidelines were adopted by PHP and distributed to their providers in October 1998. Numerous methods of communication were used to encourage the use of EPSDT services. Outreach efforts include the distribution of Member Handbooks, member service representatives, community awareness programs, physician office education agenda, quarterly member newsletters ("Take Five") and school IEP process. All areas of written communication were used by THP, including sending new member letters within one week of receiving eligibility and actions to address returned mail. All individuals were informed, such as parent/guardian, eligible pregnant women, families in WIC program, school administration and health departments. THP is in the process of establishing a Preventive Service Database capable of generating notices to members, and has identified January 28, 2000, as the target date for implementation. This database would enable the delegated organization to notify members of pending or past due EPSDT services. Newsletters are sent out quarterly with the last one sent out the third quarter of this year. Again PHP/THP are in transition due to the dramatic downsizing of PHP and the delegation of quality improvement to THP. Both organizations are working diligently to improve the EPSDT Program.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: MART DOWDEN, RN

DATE: 12/27/99

RE: SUMMARY OF MEMPHIS MANAGED CARE/TLC EPSDT OUTREACH AND INFORMING ACTIVITIES

TLC has developed a number of methods to encourage the use of EPSDT services. Outreach efforts include the distribution of Member Newsletters, Preventive Care Guidelines and maintains a comprehensive Brochure Distribution List. TLC participates in Health Fairs and Clinics in collaboration with Memphis and Shelby County Health Department Immunization Council and the TennCare Shelter Enrollment Project. Brochures and incentives for members to utilize EPSDT services include, but are not limited to; TLC Preventive Health Services Brochure, EPSDT Brochure, "Shots For Tots" Reminder Cards, Growth and Development Planner, The Facts About Immunization Brochure. TLC utilizes an "Enhanced Risk Appraisal program (EHRA) and a "Well-Chek," (Ages 14 and above), assessment tool to encourage enrollees to maintain current positive health behaviors. TLC conducted a 1998 Immunization Study of Twenty-Four Month Old Children to ascertain adherence to the Centers for Disease Control (CDC) immunization guidelines for children reaching their second birthday. Results of the study were reported to the TLC Medical Advisory Committee in August 1999. TLC has reviewed provider compliance with EPSDT at selected sites in their service area with results reported to the provider, the provider aggregate of peers and the TLC Medical Advisory Committee.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: Kasi Tiller

FROM: Barbara Evans, RN

DATE: 12/27/99

RE: Summary of BlueCare EPSDT Outreach and Informing Activities

BlueCare has developed 3 different types of oral member orientation methods because all members do not comprehend information in the same way. They have a member orientation video (an overview of BlueCare and EPSDT benefits), a healthy bingo (health topics in the place of numbers), and a member orientation session conducted by field service representatives. Field service reps also participate in Immunization Fairs at the request of the health departments.

Written communication programs include proactive member and provider components. The member component includes postcards that are mailed to the parent or guardian of a member one month prior to the ages of the American Academy of Pediatrics periodicity schedule. The provider notification is a list sent to primary care managers of their assigned members who were sent a member notification postcard.

Bright Futures program is an incentive based program for new and expectant moms with the purpose of teaching mothers the importance of EPSDT. Applications are available at health departments, DHS, Housing Manager Offices, and provider offices.

The BC Bear Cub Club is a school-based program to teach healthy habits to children in kindergarten through third grades. Teachers are given teacher's guides, which include health activities, and children receive a BC Bear Cub Club booklet.

Field service representatives also make quarterly visits to homeless shelters, health departments, foster parent associations, group homes, and public housing developments. In addition to the external contacts, BlueCare also established the Hispanic Task Force (to develop health education programs for the Hispanic community), and an EPSDT Task Force (to obtain input and collaborate with other MCO's, health departments, and patient advocates on issues related to improvement of the EPSDT compliance rate).

Memorandum

To: Kasi Tiller

From: BHO Quality Oversight Division

Date: 12/29/99

Re: Summary of Premier Behavioral Systems EPSDT Outreach and Informing Activities

---

Premier has used many different types of oral communication such as outreach representatives, provider relations, community awareness programs and member services representatives in order to provide information to members and the community in general. Premier has facilitated training sessions and workshops for providers statewide, as well as field representatives facilitating regional planning meetings with the providers to discuss needs specific to their region.

Written communication programs for Premier include new member letters, member newsletters, an annual member handbook, and a newly developed system that tracks returned mail. Premier has developed policies and procedures to support this new tracking system.

The parents/guardians of children that are newly eligible receive information about EPSDT when they receive a new member letter as well as a member handbook, which explains the EPSDT process. In addition, administrators of institutions are informed of EPSDT through a copy of the provider manual, which all administrators receive.

Premier coordinates with outside agencies such as Tennessee Voices for Children, TDMHMR Children's Issues Committee, Tennessee Medical Association, the Family Violence and Homeless Shelters in Tennessee and participates in the EPSDT Task Force.

Premier has developed an internal tracking system that will track any complaints, compliments and grievances regarding EPSDT. Furthermore, any past due EPSDT services for each member can be determined through their computer system for members with special behavioral health needs.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

DATE: December 28, 1999

TO: Kasi Tiller

FROM: Patrick Baumann RN

SUBJECT: Summary OF VANDERBILT COMMUNITY CARE EPSDT OUTREACH AND INFORMING SURVEY

Vanderbilt Community Care informs their members about EPSDT programs through a wide range of services that include community awareness programs, member services representatives, posters, flyers, brochures, new member letters, annual member handbook, and outreach representatives. VHP identifies members that are TennCare eligible from birth up to age 21. VHP monitors the effectiveness of the EPSDT Program by using birthday mailers, Medical Treasure Passport for Life, phone calls, quarterly newsletters, community outreach activities such as WIC Program, Head Start, Health Department, AFDC, and by informing educational systems i.e. "Day Care Centers and Schools. VHP has an internal tracking system in place that can determine pending service due dates and past due EPSDT services. VHP has a program that will in January 2000, systematically notify all EPSDT eligible members and their families about services and benefits. VHP EPSDT Program also includes a procedure to contact members who are blind, deaf, illiterate, and identifies non-English speaking families and provides them with the appropriate information in their language. VHP'S survey is concise, easy to follow, and demonstrates their willingness to provide members with a program that is fully functional and readily available to all TennCare eligible members and their families.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: JEAN McIVER R.N.

DATE: 12/30/99

RE: SUMMARY OF PRUDENTIAL HEALTH CARE EPSDT OUTREACH AND INFORMING ACTIVITIES

Prudential Health Care informs members about EPSDT services available through A quarterly member newsletter, community awareness program, annual Member Handbook, and brochures. Prudential Health Care has in place an Internal Tracking System to monitor members who are past due for EPSDT services which allows the generation of a reminder letter to be sent to the enrollee.

As of December 31, 1999, Prudential Health Care will no longer be a Tenn Care provider.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

DATE: December 28, 1999

TO: Kasi Tiller

FROM: Patrick Baumann RN

SUBJECT: Summary OF OmniCare EPSDT Outreach and Informing Activities

OmniCare informs their members about EPSDT services through a new program called "OmniKids". This program will facilitate obtaining complete information on children who are enrolled in the program, ages birth through six years. OmniCare also informs members by using mailings, newsletters, health-o-grams, and surveys. OmniCare has a partial internal tracking system in place. They can determine past due EPSDT services, and have a policy outlining the mechanism of attempts to contact members regarding EPSDT services that are declined. OmniCare uses posters and brochures that are printed in multiple languages such as Arabic, Spanish, Somolian, Vietnamese, and Bosnian. There are also procedures in place to contact members who are blind, illiterate, and deaf. Omnicare has a process in place to monitor the effectiveness of these procedures. Omnicare is making progress towards accomplishing, in a timely manner, the child's TennCare eligibility and setting in motion the program of EPSDT for its members.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: MART DOWDEN, RN

DATE: 12/27/99

RE: SUMMARY OF JOHN DEERE HEALTH CARE EPSDT OUTREACH AND INFORMING ACTIVITIES

John Deere Health Care informs members about EPSDT services available through distribution of brochures, e.g. "Preventive Care Program," "New Generations," and "Be Wise...Immunize." Public Service announcements informing members of EPSDT services are played for callers waiting after dialing the Member Services number. New Member Letters and quarterly "health Talk" newsletters also inform members of available EPSDT services. JDHC has a comprehensive "2000 Timeline" Action Plan for monitoring areas of Member Education, Provider Education, PCP Access and Availability, and Compliance Reporting. This Action Plan focuses on specific recommendations, areas of responsibility, priorities and target dates for completion. JDHC has in place an Internal Tracking System to monitor members who are past due for EPSDT services which allows the generation of a reminder letter to be sent to the enrollee.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF HEALTH
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

MEMORANDUM

TO: KASI TILLER

FROM: JEAN McIVER R.N.

DATE: 12/30/99

RE: SUMMARY OF ACCESS MedPLUS HEALTH CARE EPSDT OUTREACH AND INFORMING ACTIVITIES

Access MedPlus informs members about EPSDT services available through New Member Notification Letter and also through distribution of brochures, e.g."New Generations," "Be Wise ....Immunize," and "Preventive Health." Other methods of communication are through Provider relations and Member services representative. AMP also sends New Member Notification Letters, as well as their annual Member Handbook. AMP does coordinate with other programs, e.g. Head Start, WIC, Health Departments, and Tenn Care Shelter Enrollment Project. AMP has in place an Internal Tracking System to monitor members who are past due for EPSDT services which allows the generation of a reminder letter to be sent to the enrollee.

MCO/BHO PSD/OUTREACH AND INFORMING SURVEY

INDIVIDUALS TO BE INFORMED

	PARENT/ GUARDIAN OF NEWLEY ELIGIBLE CHILD	TENNCARE ELIGIBLE PREGNANT WOMEN	FAMILIES IN WIC PROGRAM	ADMINISTRATOR OF INSTITUTION
ACCESS MED PLUS	X	X	X	X
BLUE CARE	X	X	X	X
J0HN DEERE	X	O	O	X
OMNI	X	X	X	O
PHP	X	X	X	X
PRUCARE	X	X	O	O
TLC	X	X	O	O
VHP	X	X	X	X
XANTUS	X	X	X	X
PREMIER	X	N/A	N/A	X
TBH	X	N/A	N/A	X

PROCEDURES IN PLACE TO CONTACT MEMBERS WHO ARE:

	BLIND	ILLITERATE	DEAF	NON-ENGISH SPEAKING	PROCESS IN PLACE TO MONITOR THE EFFECTIVENESS OF THESE PROCEDURES
ACCESS MED PLUS	X	X	X	X	X
BLUE CARE	X	X	X	X	X
J0HN DEERE	O	O	X	X	X
OMNI	X	X	X	X	X
PHP	O	O	O	O	O
PRUCARE	O	O	O	O	O
TLC	X	O	X	X	X
VHP	X	X	X	X	X
XANTUS	X	O	X	X	O
PREMIER	X	X	X	X	X
TBH	X	X	X	X	X

X= submitted documentation
O=documentation not submitted
N/A= not applicable

MCO/BHO PERSDI OUTREACH AND INFORMING SURVEYS

SUBMITTED POLICY OUTLINING MECHANISM OF DOCUMENTATION OF ATTEMPTS TO CONTACT MEMBER REGARDING PERSDI SERVICES AND DOCUMENTATION OF PERSDI SERVICES THAT ARE DECLINED	
ACCESS MED PLUS	X
BLUE CARE	X
JOHN DEERE	X
OMNI	X
PHP	O
PRUCARE	O
TLC	X
VHP	X
XANTUS	X
PREMIER	X
TBH	X

SUBMISSIONS:

	LAST FOUR MEMBER NEWSLETTERS	POLICY FOR DISTRIBUTION OF POSTERS AND BROCHURES
ACCESS MED PLUS	X	X
BLUE CARE	X	O
JOHN DEERE	X	X
OMNI	X	X
PHP	X	O
PRUCARE	O	O
TLC	X	X
VHP	X	X
XANTUS	X	X
PREMIER	X	O
TBH	X	O

X=submitted documentation
O=documentation not submitted
N/A= not applicable

2 Week Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

- ☐ Breast ____ min ____ per day
- ☐ Formula ____ oz per day
  - Type or brand _____
  - With iron ☐ Yes ☐ No
- ☐ City water ☐ Well water
- WIC ☐ Yes ☐ No

Neonatal Metabolic Screen in Chart

☐ Yes ☐ No

Urine Output

Normal Decreased
Strong stream (If male)

Stools

Normal Diarrhea /day
Hard /day

Sleep

Normal (2–4 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- Car seat
- Smoke-free environment
- Smoke detectors
- Crib safety
- Baths
- Water temperature <120°
- Child proof home

Nutrition

- Increase formula
- Breast or iron-fortified formula
- Infant weight gain
- Colic crying

Health

- Sleep on back
- Know signs of illness
- Thermometer use; antipyretics
- Emergency procedures
- No bottle in bed
- Bowel movements
- Cord, circumcision care

Social/Behavior

- Baby's temperament
- Console baby, hold, cuddle, rock, talk, sing
- Encourage partner to care for infant
- Support from family/friends
- Postpartum check-up
- Child care

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht ____ in ____ %ile
Wt ____ lbs ____ oz ____ %ile
Head Circumference ____ cm ____ %ile
(See chart on separate page)

Patient Undressed ☐ Yes ☐ No

- ☐ General Appearance
- ☐ Head
- ☐ Eyes
- ☐ Ears
- ☐ Nose
- ☐ Oropharynx
- ☐ Gums/Palate
- ☐ Neck
- ☐ Lungs
- ☐ Heart
- ☐ Abdomen
- ☐ Genitalia
- ☐ Extremities/Hips
- ☐ Spine
- ☐ Neurological
- ☐ Skin/Nodes
- ☐ Other

☐ Additional documentation on back
☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Hearing

- ☐ Responds to sounds
- Neonatal ABR or OAE results in chart

Impression

- ☐ Well infant
  - Normal growth
  - Normal development
- ☐ Other

Plan

- ☐ Family history, birth history
- Newborn metabolic screen:
  - Normal ☐ Pending ☐ Today
- WIC for 2 month well check
- ☐ Referrals:
  - ☐ WIC
  - ☐ Transportation
  - ☐ Other referrals

Other

Sign _____

4 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

[ ] Breast _____ min _____ per day
[ ] Formula _____ oz per day
Type or brand _____
With iron [ ] Yes [ ] No
[ ] City water [ ] Well water
WIC [ ] Yes [ ] No

Neonatal Metabolic Screen In Chart

[ ] Yes [ ] No

Urine Output

Normal Decreased

Stools

Normal Diarrhea /day
Hard /day

Sleep

Normal (4-6 hours)

New Symptoms/Problems/Complaints

Safety

Anticipatory Guidance Health Education (✓ if discussed)

Car seat
Water temperature < 120°
Smoke-free environment
Smoke detectors
Child proof home
No baby walker

Nutrition

Breastfeed or iron-fortified formula
Introduce solid food
Avoid honey

Health

Know signs of illness
Sleep on back
Syrup of Ipecac

Social/Behavior

Hold, cuddle, rock
Talk, sing, play music
Partner and sibling involvement
Community involvement
Bedtime routine

Physical Exam ✓= WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %ile
Wt _____ lbs _____ oz _____ %ile
Head Circumference _____ cm _____ %ile
(See chart or separate page)

Parent Undressed [ ] Yes [ ] No

[ ] General Appearance
[ ] Head
[ ] Eyes
[ ] Ears
[ ] Nose
[ ] Oropharynx
[ ] Gums/Palate
[ ] Neck
[ ] Lungs
[ ] Heart
[ ] Abdomen
[ ] Genitalia
[ ] Extremities/Hips
[ ] Spine
[ ] Neurological
[ ] Skin/Nodes
[ ] Other

[ ] Additional documentation on back
[ ] Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

[ ] WNL
[ ] ABN (See separate page)

Vision

[ ] Parental observation/concerns
[ ] Fixes and follows

Hearing

[ ] Parental observations/concerns
Responds to sound (parent report)
[ ] Responds to noisemaker (optional)

Impression

[ ] Well infant
[ ] Normal growth
[ ] Normal development
[ ] Other

Plan

[ ] History updated
[ ] Problem list, allergies, medication list updated
[ ] Immunizations
  [ ] Up to date
  [ ] Info read and discussed
  [ ] DTaP/DTP [ ] IPV [ ] HBV [ ] Hib
[ ] Acetaminophen _____ mg q 4 hours
[ ] Handouts given (4 Mo.)
[ ] RTC for 6 month well check
[ ] Referrals
  [ ] WIC
  [ ] Transportation
  [ ] Other referrals

[ ] Other

Sign _____

9 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

- [ ] Breast _____ min _____ per day
- [ ] Formula _____ oz per day
  - Type or brand _____
  - With iron [ ] Yes [ ] No
- [ ] City water [ ] Well water

WIC [ ] Yes [ ] No

Neonatal Metabolic Screen In Chart

[ ] Yes [ ] No

Urine Output

Normal Decreased

Stools

Normal Diarrhea /day

Hard /day

Sleep

Normal (8 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

Check hazards
Smoke-free environment
No baby walker
Child proof home
Assess lead risk
Car seat
Empty buckets

Nutrition

Breastfeed or iron-fortified formula
Finger foods, mashed food
Avoid choke foods
Supervise eating
Drink from a cup

Health

Brush teeth
Fluoride
Water temperature < 120°
No bottle in bed

Social/Behavior

Partner and sibling involvement
Talk, sing
Pat-a-cake, peek-a-boo
Bedtime routine
Exploration opportunities
Limit but enforce rules
Role model healthy habits

Physical Exam ✓ = WNL, X = ABN (Describe abnormal findings)

Ht _____ in: _____ %ile

Wt _____ lbs _____ oz _____ %ile

Head Circumference _____ cm _____ %ile

(See chart on separate page)

Patient Undressed [ ] Yes [ ] No

- [ ] General Appearance
- [ ] Head
- [ ] Eyes
- [ ] Ears
- [ ] Nose
- [ ] Oropharynx
- [ ] Gums/Palate
- [ ] Neck
- [ ] Lungs
- [ ] Heart
- [ ] Abdomen
- [ ] Genitalia
- [ ] Extremities/Hips
- [ ] Spine
- [ ] Neurological
- [ ] Skin/Nodes
- [ ] Other

[ ] Additional documentation on back
[ ] Additional documentation on separate page

Screening ✓ = WNL, X = ABN

Developmental/Behavioral Screen

- [ ] WNL (See separate page)
- [ ] ABN

Vision

- [ ] Parental observation/concerns
- [ ] Fixes and follows

Hearing

- [ ] Parental observations/concerns
- [ ] Responds to voice and noise (parent report)
- [ ] Responds to noisemaker (optional)

Impression

- [ ] Well child
- [ ] Normal growth
- [ ] Normal development
- [ ] Risk assessment for lead exposure

Other

Plan

- [ ] History updated
- [ ] Problem list, allergies, medication list updated

Immunizations

- [ ] Up to date
- [ ] Info read and discussed
- [ ] No adverse reactions to prior imm
- [ ] HBV#1 Other

- [ ] Hct or Hgb
- [ ] Lead level mcg/dl
- [ ] Acetaminophen mg q 4 hours
- [ ] PPD (result)
- [ ] Handouts given (9 Mo.)
- [ ] RTC for 12 month well check
- [ ] Referrals
  - [ ] WIC
  - [ ] Transportation
  - [ ] Other referrals

[ ] Other _____

Sign _____

15-18 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

- [ ] Whole milk, cup only
- [ ] Solids (serv/day)
  - ___ Meat/Egg
  - ___ Veg/Fruit
  - ___ Bread/Cereal
- [ ] other

[ ] City water [ ] Well water [ ] Bottled water

WIC [ ] Yes [ ] No

Urine Output

Normal Decreased

Stools

Normal Diarrhea ___/day

Hard ___/day

Sleep

Normal (8-12 hours)

Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- Car seat/ Airbags
- Crib safety/ Crib mattress lowered
- Childproof home
- Window guards
- Smoke-free environment
- Choke foods

Nutrition

- Wean from bottle
- Safe table foods
- Healthy food choices/ No forced foods
- Self-feeding/ Drinking from cup
- Family meals

Health

- Brush teeth
- Proper use of phone/ER

Social/Behavior

- Individual attention
- Exploration/ Physical activity
- Hitting, biting, aggressive behavior
- Enforce rules/ Reassure once negative behavior stops
- Family playtime
- Help toddler express anger/joy
- Short family outings
- Older children
- Toilet training
- Community Programs/ Preschool
- Peek-A-Boo/Pat-A-Cake

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht ___ in ___ %ile

Wt ___ lbs ___ oz ___ %ile

Head Circumference ___ cm ___ %ile

(See chart on separate page)

Patient Undressed [ ] Yes [ ] No

[ ] General Appearance

[ ] Head

[ ] Eyes

[ ] Ears

[ ] Nose

[ ] Oropharynx

[ ] Gums/Palate

[ ] Neck

[ ] Lungs

[ ] Heart

[ ] Abdomen

[ ] Genitalia

[ ] Extremities/Hips

[ ] Spine

[ ] Neurological

[ ] Skin/Nodes

[ ] Other

[ ] Additional documentation on back

[ ] Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

[ ] WNL

[ ] ABN (See separate page)

Vision

[ ] Parental observation/concerns

[ ] Can see small objects

Hearing

[ ] Parental observations/concerns

[ ] Responds to voice and noise (parent report)

[ ] Responds to noisemaker (optional)

Impression

Well child

Normal growth

Normal development

Low risk for lead exposure

[ ] Low risk for tuberculosis

[ ] Other

Plan

[ ] History updated

[ ] Problem list, allergies, medication list updated

[ ] Immunizations

- [ ] Up to date
- [ ] Info read and discussed
- [ ] No adverse reactions to prior imm.
- [ ] DTaP/DTP [ ] Hib [ ] MMR

[ ] Hct or Hgb

[ ] Referrals

- [ ] WIC
- [ ] Transportation
- [ ] Other referrals

[ ] Other _____

Sign _____

3 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

[ ] Food (serv/day)
___ Meat/Egg
___ Veg/Fruit
___ Bread/Cereal
[ ] other ___
[ ] City water [ ] Well water [ ] Bottled water
WIC [ ] Yes [ ] No

Urine Output

Normal Decreased

Stools

Normal Diarrhea ___/day
Hard ___/day

Sleep

Normal (8-12 hours)
Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

Playground/Stranger
Seatbelts/Booster seats
Fires/Burns

Nutrition

See Dentist/ Brush teeth
Family meals
Variety/Low fat/Limit sweets

Social/Behavior

Exploration/ Physical activity
Socialization
Praise/ Talking/ Interactive reading
Sibling relationships
Limit TV

Physical Exam ✓= WNL, X=ABN (Describe abnormal findings)

Ht ___ in ___ %ile
Wt ___ lbs ___ oz ___ %ile
(See chart on separate page)

Patient Undressed [ ] Yes [ ] No

[ ] General Appearance

[ ] Head

[ ] Eyes

[ ] Ears

[ ] Nose

[ ] Oropharynx

[ ] Gums/Palate

[ ] Neck

[ ] Lungs

[ ] Heart

[ ] Abdomen

[ ] Genitalia

[ ] Extremities/Hips

[ ] Spine

[ ] Neurological

[ ] Skin/Nodes

[ ] Other

[ ] Additional documentation on back
[ ] Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

[ ] WNL (See separate page)
[ ] ABN

Vision

[ ] Parental observation/concerns
[ ] Can see small objects
[ ] Ocular alignment
[ ] Visual acuity (optional)
R ___ L ___ Both

Hearing

Parental observations/concerns
[ ] Screening audiometry (optional)
[ ] Screening with noisemaker (optional)

Impression

[ ] Well child
[ ] Normal growth
[ ] Normal development
[ ] Low risk for lead exposure
[ ] Low risk for tuberculosis
[ ] Low risk for hyperlipidemia

Plan

[ ] History updated
[ ] Problem list, allergies, medication list updated
[ ] Immunizations
  [ ] Up to date
  [ ] Info read and discussed
  [ ] No adverse reactions to prior imm.
[ ] Hct or Hgb ___
[ ] Acetaminophen ___ mg q 4 hours
[ ] Handouts given (3 year)
[ ] Urinalysis
[ ] RTC for 4 year well check
[ ] Referrals
  [ ] WIC
  [ ] Transportation
  [ ] Dental
  [ ] Other referrals ___
[ ] Other ___

Sign ___

V.f.9.

5 Year Preventive Visit Form

DATE ____ NAME ____ DOB ____

Allergies: ____

Meds: ____

History

Nutrition

- Food (serv/day)
  - Meat/Egg
  - Veg/Fruit
  - Bread/Cereal
  - Milk/Dairy
- other
- City water / Well water / Bottled water

WIC Yes / No

Urine Output

Normal / Decreased

Stools

Normal / Diarrhea /day

Hard /day

Sleep

Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- Pedestrian/Playground/Stranger
- Car seat/Seat belt/Bike Helmet

Nutrition

- Healthy meals and snacks
- Dental sealants
- Family meals

Health

- Adequate sleep/Physical activity
- Tooth care/Dental exams
- Curiosity about sex

Social/Behavior

- Family Rules/Respect/Right from wrong
- Praise/Encourage
- Handle anger/Conflict resolution
- Prepare child for school
- Tour school/Meet teachers
- Affection

Physical Exam ✓= WNL, X=ABN (Describe abnormal findings)

Ht in %tile

Wt lbs oz %tile

(See chart on separate page)

Patient Unclothed Yes / No

- General Appearance
- Head
- Eyes
- Ears
- Nose
- Oropharynx
- Gums/Palate
- Neck
- Lungs
- Heart
- Abdomen
- Genitalia
- Extremities/Hips
- Spine
- Neurological
- Skin/Nodes
- Other

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- WNL
- ABN (See separate page)

Vision

- Parental observation/concerns
- Can see small objects
- Ocular alignment
- Visual acuity (optional)

R L Both

Hearing

- Parental observations/concerns
- Screening audiometry, if not done at 3 or 4 years

Impression

- Well child
- Normal growth
- Normal development
- Low risk for lead exposure
- Low risk for tuberculosis
- Low risk for hyperlipidemia
- Other

Plan

- History updated
- Problem list, allergies, medication list updated
- Immunizations
  - Up to date
  - Info read and discussed
  - No adverse reactions to prior imm.
  - DTaP/DTP IPV HBV MMR
- Other
- Hct or Hgb
- UA
- PPD
- Lead level mcg/dl
- Urinalysis
- RTC for 6 year well check
- Referrals
  - Transportation
  - Dental
  - Other referrals
- Other

☐ Additional documentation on back

☐ Additional documentation on separate page

Sign ____

10-14 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition
- [ ] Food (serv/day)
  - ___ Meat/Egg
  - ___ Veg/Fruit
  - ___ Bread/Cereal
  - ___ Milk/Dairy
  - ___ other _____
- [ ] City water [ ] Well water [ ] Bottled water

Urine Output
- Normal Decreased

Stools
Normal Diarrhea ___/day
Hard ___/day

Sleep
Normal (8-12 hours)
Abnormal

Menstrual
Premenarchal
Normal
Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety
Seatbelts/Helmets/Sunscreen
Weapons

Nutrition
Variety/Limit sweets
Adequate Iron in females
See Dentist
Weight management
Weight training/Changes
Adequate sleep/Exercise

Health
See Dentist
Stress/Nervousness/Sadness
Alcohol/ Drugs/ Tobacco
How to say no/Abstinence
Sexual feelings normal
Body changes

Social/Behavior
Family time
Peer pressure/Refusal
School activities
Religious/Cultural/Volunteer activities

Physical Exam ✓ = WNL, X=ABN (Describe abnormal findings)

Ht ___ in ___ %tile
Wt ___ lbs ___ oz ___ %tile
(See chart on separate page)

Patient Unclothed [ ] Yes [ ] No

- General Appearance
- [ ] Head
- [ ] Eyes
- [ ] Ears
- [ ] Nose
- [ ] Oropharynx
- [ ] Gums/Palate
- [ ] Neck
- [ ] Lungs
- [ ] Heart
- [ ] Abdomen
- [ ] Genitalia
- [ ] Extremities/Hips
- [ ] Spine
- [ ] Neurological
- [ ] Skin/Nodes
- [ ] Other

[ ] Additional documentation on back
[ ] Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen
- Sexual development and behaviors (abstinence, STD prevention, BC)
- Tobacco/Alcohol/Substance Anabolic steroid use/avoidance
- Body image and dieting patterns
- [ ] Emotional, physical and sexual abuse
- [ ] Emotional (Depression, Anxiety)
- [ ] School/Work problems
- [ ] Peer relationships
- [ ] Family relationships

Vision
- [ ] Patient concerns
- [ ] Visual acuity
  ___ R ___ L ___ Both

Hearing
- [ ] Patient concerns
- [ ] Screening audiometry, if not done previously

Impression

- Well adolescent
- [ ] Normal growth
- [ ] Tanner Stage
- [ ] Normal development
- [ ] Low risk for tuberculosis
- [ ] Low risk for hyperlipidemia
- [ ] Other

Plan

- History updated
- [ ] Problem list, allergies, medication list updated
- [ ] Immunizations
  - [ ] Up to date [ ] HBV [ ] Td
  - [ ] MMR [ ] Varicella
- [ ] Other _____
- [ ] Hct or Hgb
- [ ] UA
- [ ] PPD
- [ ] School Forms completed
- [ ] Urinalysis
- [ ] RTC for well check
- [ ] Referrals
  - [ ] Transportation
  - [ ] Dental
  - [ ] Other referrals _____
- [ ] Other _____

Sign _____

Attachment C

EPSDT Articles

TNCare Changes Child Health Supervision Visit Requirements

In March of 1998 the State of Tennessee entered into a consent decree mandating that it fulfill Federal Early Periodic Screening Diagnosis and Treament (EPSDT). Major requirements of the consent decree include the adoption of the screening schedule found in the American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care and from the American Dental Association. To facilitate and define these guidelines, the Bureau of TennCare convened an EPSDT Screening Guidelines Committee with broad representation from various health care specialties, including Pediatrics, Family Medicine and Nursing.

The Committee focused on vision, hearing, developmental and behavioral screening methods suitable for busy primary care settings. Technical characteristics of various measures and methods reviewed were the reliability and validity of the procedures, with particular attention to the sensitivity and specificity of the instrument in detecting problems. Cost and the practicality of administering the screens were also important considerations. Behavioral and developmental screens posed a particular challenge due to the need to tailor screens to meet the multiplicity of needs of children from infancy through adolescents.

An extensive pilot study was conducted during the summer of 1999 in two large practices to evaluate the recommended screenings. To further facilitate documentation and fulfillment of EPSDT requirements, the committee worked closely with a committee of the Tennessee Pediatric Society who developed age-specific encounter forms that incorporate components of the EPSDT visit.

including Family Medicine, to develop the guidelines. The consent decree also requires the adoption of the screening schedule found in the American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care. (Dental screens are also part of this process and American Dental Association Guidelines were adopted to fulfill this requirement)

The task for the committee was to recommend screening guidelines that might be readily adaptable to primary care settings. Technical characteristics reviewed were the reliability and validity of the procedures, with particular attention to the sensitivity and specificity of the instrument in detecting problems. Cost and the practicality of administering the screens were also important considerations. Behavioral and developmental screens posed a particular challenge due to the need to tailor screens to meet the multiplicity of needs of children from infancy through adolescents.

An extensive pilot study was conducted during the summer of 1999 in two large practices to evaluate the recommended screenings. To further facilitate documentation and fulfillment of EPSDT requirements, the committee worked closely with a committee of The Tennessee Pediatric Society who developed chart forms that incorporate components of the EPSDT visit.

The outcome of the process is a series of recommended guidelines that the committee considers being the most appropriate practices now available. Hearing and vision guidelines incorporate recommendations for objective and subjective screens. There are

Attachment D

Schedule of EPSDT Guidelines Training Workshops and Tentative Agenda

Tentative Agenda
(Jackson and Memphis locations only)

9:00 – 9:30	Registration
9:30 – 11:00	Introduction/EPSDT Overview A. EPSDT Requirements B. EPSDT Consent Decree C. EPSDT Screening Guidelines Committee
11:00 – 12:00	Hearing/Vision Screening Guidelines
12:00 – 1:00	Lunch
1:00 – 2:00	Behavioral/Developmental Guidelines
2:00 – 2:30	Enhancing the EPSDT Program in Your Practice
2:30 – 3:00	Wrap-up/Questions & Answers

Attachment E

HCFA Report 416
and
Progress Toward EPSDT Targets

DATE 05/02/00

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT
TENNCARE MANAGEMENT INFORMATION SYSTEM
REPORTING PERIOD OCT 01, 1998 - SEP 30, 1999

TNMEP500
DHHS/HCFA

FORM APPROVED
OMB NO- 0938-035[illegible]

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

STATE TN FY 1999

	CAT	TOTAL	AGE GROUPS <1	1-2 *	3-5	6-9	10-14	15-18	19-2[illegible]
9. TOTAL ELIGIBLES RECEIVING AT LEAST ONE INITIAL OR PERIODIC SCREEN	CN	86045	15073	20122	18932	9076	9728	7996	511[illegible]
	MN	72401	8781	14166	16164	7576	8663	11097	595[illegible]
	TOTAL	158446	23854	34288	35096	16652	18391	19093	1107[illegible]
10. PARTICIPANT RATIO	CN	.27	.51	.28	.33	.25	.14	.23	.35
	MN	.25	.61	.33	.35	.25	.13	.18	.22
	TOTAL	.26	.54	.30	.34	.25	.14	.20	.26
11. TOTAL ELIGIBLES REQ FOR CORRECTIVE TREATMENT	CN	121565	15774	22076	22874	19964	21727	12756	6394
	MN	115742	9122	15852	19980	19329	22211	20417	8831
	TOTAL	237307	24896	37928	42854	39293	43938	33173	15225
12A. TOTAL ELIGIBLES RECEIVING ANY DENTAL SERVICES	CN	97061	1928	5848	18206	27583	25030	12460	6006
	MN	104337	1151	5098	16819	26231	25460	20567	9011
	TOTAL	201398	3079	10946	35025	53814	50490	33027	15017
12B. TOTAL ELIGIBLES RECEIVING PREVENTIVE DENTAL SERVICES	CN	74558	433	3390	15070	24498	21531	7577	2059
	MN	78936	176	2582	13719	23065	21694	13454	4246
	TOTAL	153494	609	5972	28789	47563	43225	21031	6305
12C. TOTAL ELIGIBLES RECEIVING DENTAL TREATMENT SERVICES	CN	37499	318	1266	6480	11155	10852	5505	1923
	MN	49436	160	1242	6900	12585	12900	11170	4479
	TOTAL	86935	478	2508	13380	23740	23752	16675	6402
13. TOTAL ELIGIBLES ENROLLED IN MANAGED CARE	CN	379260	29291	71666	62734	78812	76797	41496	18464
	MN	343589	14508	42550	50537	66168	69843	68048	31935
	TOTAL	722849	43799	114216	113271	144980	146640	109544	50399
14. TOTAL NUMBER OF SCREENING BLOOD LEAD TESTS	CN	10615	2334	2847	4396	690	269	65	14
	MN	5864	1301	1846	2192	328	123	51	23
	TOTAL	16479	3635	4693	6588	1018	392	116	37

* INCLUDES 12-MONTH VISIT
NOTE: "CN" = CATEGORICALLY NEEDY, "MN" = MEDICALLY NEEDY

FORM HCFA-416 (06-02)

Attachment G

Summary of EPSDT Screens for Children in DCS Custody

The March report consists of three charts. Table 1 reflects the number and percent of children that had been in custody 30 or more days who had an EPSDT screen by the end of March. This report represents the cumulative percentage of children in the Department of Children's Services custody who have a current EPSDT screen. By the end of March, the EPSDT exam completion rate for children in custody was 75%. Regional completion rates varied from 64% in Hamilton County to 90% in the Northwest region.

Table 2 shows the number of children under age three who had been in custody 30 days or more who had been given a dental screening by the end of March. The statewide percentage of children with dental exams was almost 71%. Sixty percent of children in Hamilton County had received dental screens. This contrasts with Knox County where 89% of children in custody had the needed dental screen.

Table 3 shows the number of children who entered state custody during March 2000, the number of these with prior EPSDT screens, the number needing a screen, and the number and percentage of screens completed within 30 days of entering care. The percentage of children with EPSDT exams completed within the first 30 days of entering custody was over 25%. Regions varied widely, with 5% of EPSDT exams reported in Shelby County, but 52% of children in Knox County receiving exams. The low numbers in some regions may be caused by data entry delays.

Attachments

Table 1: Department of Children's Services Completion Rates of EPSDT Screens by Region as of March 31, 2000 (Cumulative)

Region	Total Number of Children to be Screened	Number of Children with EPSDT Screens Completed within the Past 365 Days	% with EPSDT Screens Completed within the Past 365 Days
Davidson	830	616	74.22%
East Tennessee	988	801	81.07%
Hamilton	502	326	64.94%
Knox	557	493	88.51%
Mid Cumberland	1,312	943	71.88%
Northeast	705	567	80.43%
Northwest	288	261	90.63%
Shelby	1,573	1,037	65.92%
South Central	591	441	74.62%
Southeast	595	471	79.16%
Southwest	725	565	77.93%
Upper Cumberland	507	395	77.91%
Department Totals	9,173	6,916	75.40%

Data pulled from TN KIDS extract dated 6/15/00

Table 2: Department of Children's Services Completion Rates of Dental Screens by Region as of March 31, 2000 (Cumulative)

Region	Children Age 3+ to be Screened	Number of Children with Dental Screens Completed with the Past 365 Days	% with Dental Screens Completed within the Past 365 Days
Davidson	741	507	68.42%
East Tennessee	909	675	74.26%
Hamilton	451	273	60.53%
Knox	495	441	89.09%
Mid Cumberland	1,206	843	69.90%
Northeast	642	499	77.73%
Northwest	270	223	82.59%
Shelby	1,387	897	64.67%
South Central	547	351	64.17%
Southeast	535	392	73.27%
Southwest	663	464	69.98%
Upper Cumberland	458	327	71.40%
Department Totals	8,304	5,892	70.95%

Data pulled from TN KIDS extract dated
Thursday, June 22, 2000

Table 3: Department of Children's Services EPSDT Screens Completed within 30 Days for Children Entering Custody During March 2000

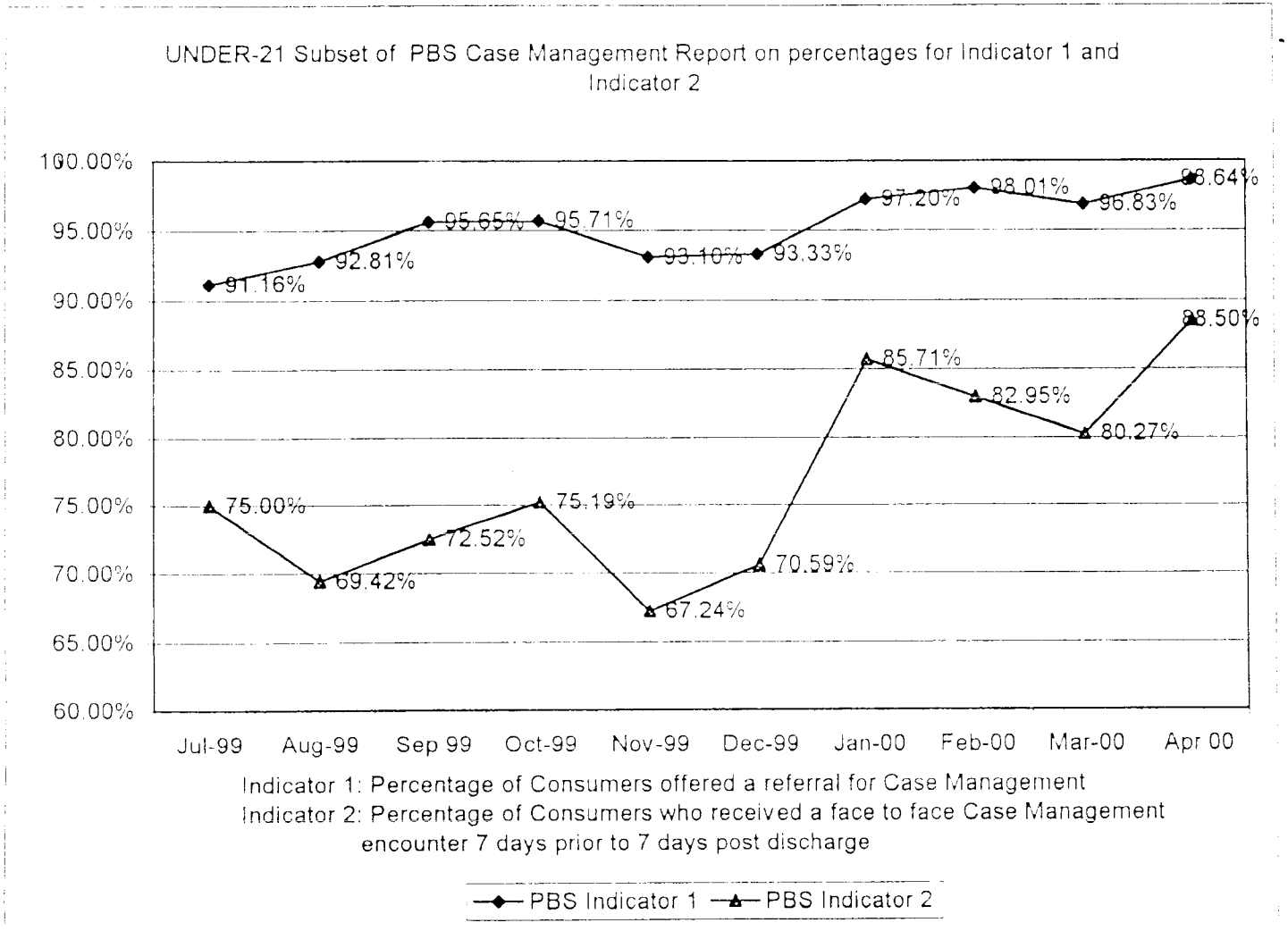
Region	Total Number of Children Entering Custody	Number of Children with EPSDT Screens within the Past 365 Days	Total Number of Children Entering Custody Needing EPSDT Screens	Number of Children with EPSDT Screens Completed within 30 Days of Entering Custody	% with EPSDT Screens Completed within 30 Days
Davidson	50	6	44	5	11.36%
East Tennessee	78	10	68	22	32.35%
Hamilton	33	4	29	15	51.72%
Knox	21	2	19	10	52.63%
Mid Cumberland	60	7	53	11	20.75%
Northeast	50	5	45	11	24.44%
Northwest	26	4	22	9	40.91%
Shelby	39	0	39	2	5.13%
South Central	58	4	54	8	14.81%
Southeast	35	2	33	16	48.48%
Southwest	56	6	50	16	32.00%
Upper Cumberland	45	4	41	4	9.76%
Department Totals	551	54	497	129	25.96%

Data pulled from TN KIDS extract dated 6/15/00

Thursday, June 22, 2000

Attachment H

BHO Case Management Reports

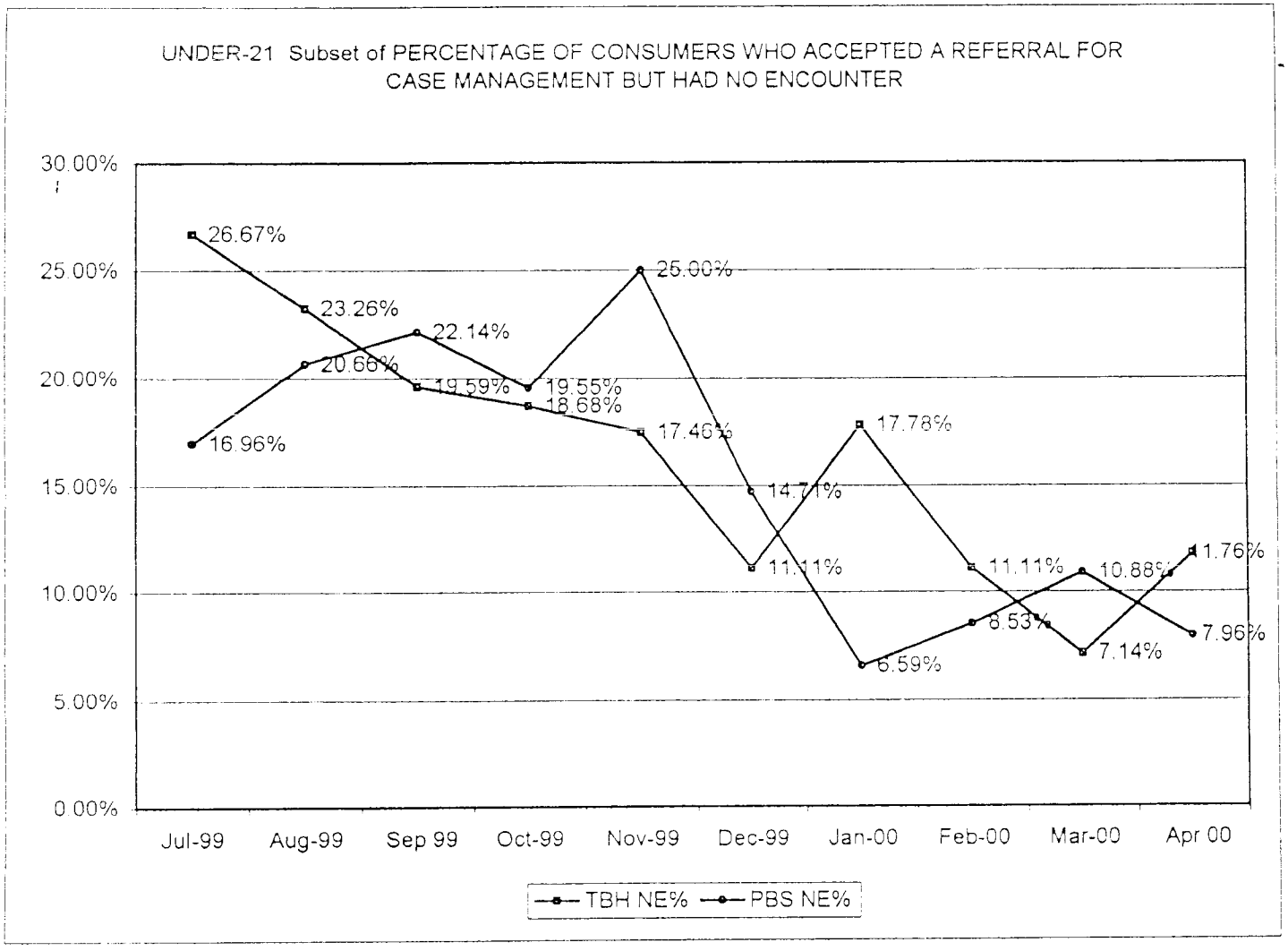

UNDER-21 Subset of PBS Case Management Report on percentages for Indicator 1 and Indicator 2
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
91.16%
92.81%
95.65%
95.71%
93.10%
93.33%
97.20%
98.01%
96.83%
98.64%
75.00%
69.42%
72.52%
75.19%
67.24%
70.59%
85.71%
82.95%
80.27%
88.50%
Jul-99
Aug-99
Sep 99
Oct-99
Nov-99
Dec-99
Jan-00
Feb-00
Mar-00
Apr 00
Indicator 1: Percentage of Consumers offered a referral for Case Management
Indicator 2: Percentage of Consumers who received a face to face Case Management encounter 7 days prior to 7 days post discharge
PBS Indicator 1
PBS Indicator 2

Attachment I

Premier and TBH Case Management Report January 2000 Barriers and Interventions

- Follow Up Specialists continue to document facility compliance with discharge planning and CMHA compliance with case management standards. The Analytical Services Department continues to provide feedback to the CMHAs and inpatient facilities of their compliance based on the Specialists' documentation. All inpatient facilities and CMHAs who do not meet compliance standards monthly will be required to submit a plan of action.
- The Supervised Systems of Care audit tools used to monitor the CMHAs continue to be revised to include increased oversight of Case Management programs.
- Measures have been added to the Treatment Record Review audit tool that focuses on discharge planning/continuity of care for both CMHAs and inpatient/residential providers.
- The BHO added to the facility report card the three following standards: 1) Discharge Timeliness, 2) Discharge Summary complete and 3) Release of Information signed
- The BHO has put follow-up specialists in the field to educate provider on the case management process.
- Corrective action plans submitted by providers for deficiencies are reviewed by Continuous Quality Improvement committee.
- Routine treatment record reviews will be ongoing by Regional Care Managers to ensure compliance with documentation standards. If standards are not met, providers must submit corrective action plans that are reviewed and monitored by the Professional Provider Review Committee.
- The BHO developed an information system to monitor compliance of facility discharges.
- The BHO mailed a memorandum to all CMHA Case Management Supervisors informing them of the Intensive Care Management program.

Ongoing collaborative efforts between the BHO, CMHAs, and Inpatient facilities will continue to ensure quality consumer services and increase community tenure for our members.


UNDER-21 Subset of PERCENTAGE OF CONSUMERS WHO ACCEPTED A REFERRAL FOR CASE MANAGEMENT BUT HAD NO ENCOUNTER
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
26.67%
23.26%
22.14%
20.66%
19.59%
19.55%
18.68%
17.46%
25.00%
14.71%
11.11%
17.78%
6.59%
11.11%
8.53%
10.88%
7.14%
11.76%
7.96%
Jul-99
Aug-99
Sep 99
Oct-99
Nov-99
Dec-99
Jan-00
Feb-00
Mar-00
Apr 00
TBH NE%
PBS NE%

Attachment J

BHO Case Management Report: Percentage of Consumers Who Accepted a Referral for Case Management but Had No Encounter

Premier and TBH Case Management Report
January 2000

Barriers

- Inpatient and residential facilities continue to lack referrals to Community Mental Health Agencies prior to or upon discharge.
- Unsuccessful attempts by the Community Mental Health Center Agency Management staff continues to exist but are decreasing each month.
- Facilities are not receiving assigned case manager's name and are not documenting the appointment on the discharge summary.
- For children and adolescents, there has been confusion by inpatient and residential treatment center providers regarding the difference between intensive in-home services and mental health case management.
- Lack of communication by inpatient facility to Community Mental Health Agency regarding the time of discharge

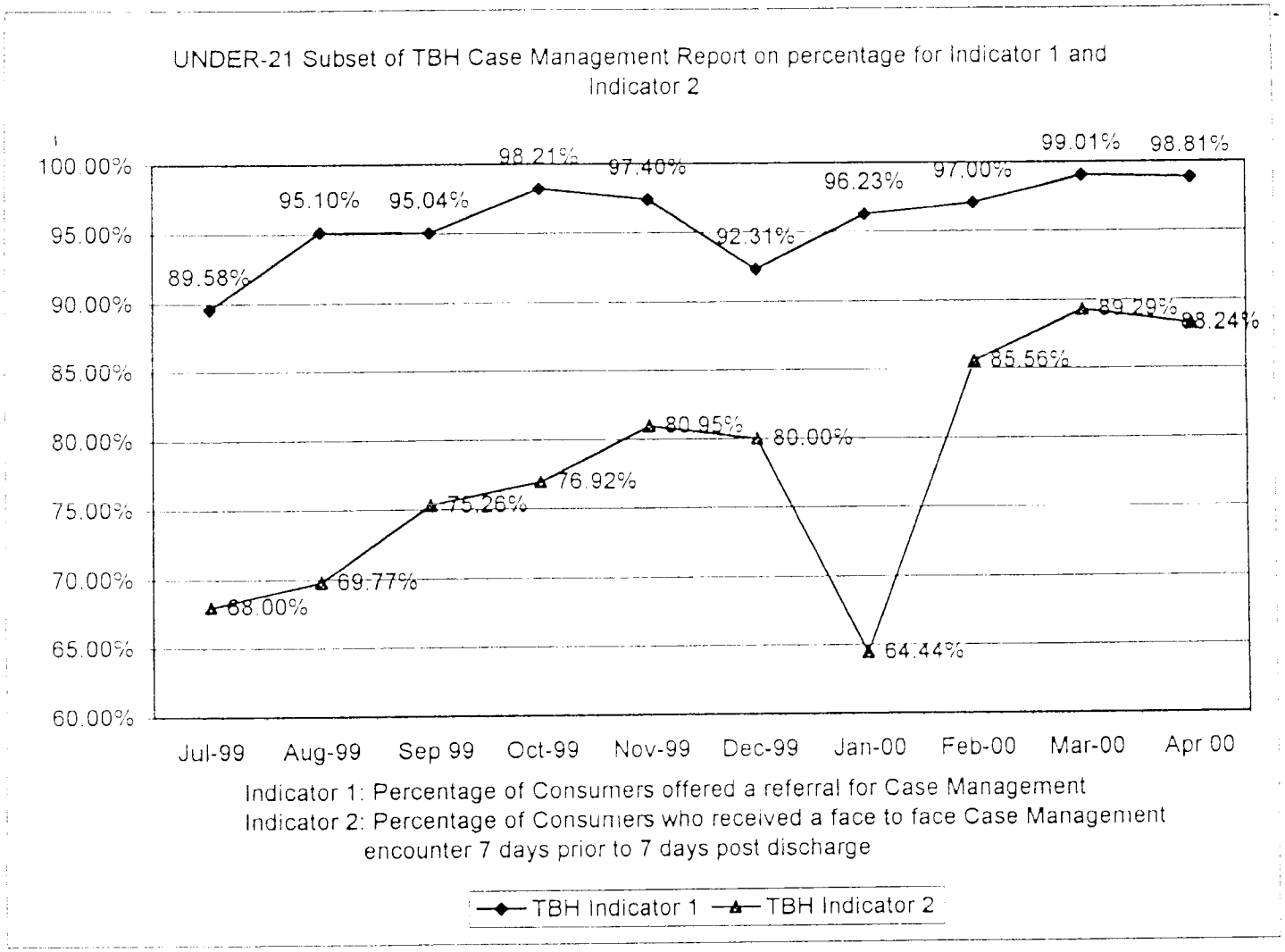
Interventions

The BHO is continuing the following interventions.

- Increase provider education to all inpatient facilities and residential treatment centers regarding which agencies provide case management services and how to access the services.
- Increase education for inpatient providers and residential treatment centers regarding the importance of case management services through CMHAs as opposed to intensive in-home services. One Follow Up Specialist has been assigned works with children's issues. This Follow Up Specialist continues to attend meetings with CMHAs, In-Home Service providers, Mobile Crisis units, and Family Preservation Network Child & Family Tennessee.
- Follow Up Specialists will continue to contact facilities who do not make case management referrals for consumers and who submit incomplete discharge summaries.
- Follow Up Specialists will attempt to link consumers with case management who are discharged from facilities with no case management referral by contacting the CMHA immediately when the discharge summary is received and it is discovered that no referral was offered.
- Follow Up Specialists will continue to be the liaison between inpatient facilities and CMHAs and encourage all providers to contact their assigned Specialists when problems persist and intervention is needed for case management referrals.
- Follow Up Specialists will continue to educate CMHAs regarding unsuccessful attempts. An unsuccessful attempt has been defined as one attempt at a face to face encounter with the consumer in the community as well as one attempted follow up phone call to the consumer.

SUBSET CASE MANAGEMENT DISCHARGE REPORTS IDENTIFYING CONSUMERS UNDER THE AGE OF 21

		Jul-99	Aug-99	Sep 99	Oct-99	Nov-99	Dec-99	Jan-00	Feb-00	Mar-00	Apr 00
TBH	Indicator 1	89.58%	95.10%	95.04%	98.21%	97.40%	92.31%	96.23%	97.00%	99.01%	98.81%
	Indicator 2	68.00%	69.77%	75.26%	76.92%	80.95%	80.00%	64.44%	85.56%	89.29%	88.24%
	NE%	26.67%	23.26%	19.59%	18.68%	17.46%	11.11%	17.78%	11.11%	7.14%	11.76%
PBS	Indicator 1	91.16%	92.81%	95.65%	95.71%	93.10%	93.33%	97.20%	98.01%	96.83%	98.64%
	Indicator 2	75.00%	69.42%	72.52%	75.19%	67.24%	70.59%	85.71%	82.95%	80.27%	88.50%
	NE%	16.96%	20.66%	22.14%	19.55%	25.00%	14.71%	6.59%	8.53%	10.88%	7.96%


UNDER-21 Subset of TBH Case Management Report on percentage for Indicator 1 and Indicator 2
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
60.00%
89.58%
95.10%
95.04%
98.21%
97.40%
92.31%
96.23%
97.00%
99.01%
98.81%
68.00%
69.77%
75.26%
76.92%
80.95%
80.00%
64.44%
85.56%
89.29%
88.24%
Jul-99
Aug-99
Sep 99
Oct-99
Nov-99
Dec-99
Jan-00
Feb-00
Mar-00
Apr 00
Indicator 1: Percentage of Consumers offered a referral for Case Management
Indicator 2: Percentage of Consumers who received a face to face Case Management encounter 7 days prior to 7 days post discharge
TBH Indicator 1
TBH Indicator 2

Attachment K

EPSDT Remedial Plan for Children in DCS Custody

REMEDIAL PLAN FOR CHILDREN IN CUSTODY

May 11, 2000

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B., CARRIE G., JOSHUA M, MEAGAN A. and ERICA A. by their next friend, L.A.; DUSTIN P. by his next friend, Linda C.; BAYLI S. by her next friend, C. W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T. W.; RAY M. by his next friend, P. D.; ROSCOE W. by his next friend, K. B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,

Plaintiffs,

v.

NANCY MENKE, Commissioner
Tennessee Department of Health;
THERESA CLARKE, Assistant Commissioner
Bureau of TennCare; and
GEORGE HATTAWAY, Commissioner
Tennessee Department of Children's Services

Defendants.

No. 3-98-0168
Judge Nixon

PARTIES' PROPOSED REMEDIAL PLAN FOR CHILDREN IN STATE CUSTODY

Pursuant to ¶¶ 88-92 of the Consent Decree for Medicaid-Based Early and Periodic Screening, Diagnosis and Treatment Services entered on March 11, 1998,[1] the parties have,

[1]After failing to reach agreement with the plaintiffs on a mutually acceptable plan, the defendants initially filed a proposed plan on December 11, 1998, as required by the Consent

TENNESSEE JUSTICE CENTER

By: Michele Johnson / Russell Overby

Gordon Bonnyman, TN BPR #2419
Michele Johnson, TN BPR #16756
Russell J. Overby, TN BPR #2520
916 Stahlman Building
211 Union Street
Nashville, Tennessee 37201
Phone: (615) 255-0331

Counsel for the Plaintiffs

TABLE OF CONTENTS FOR REMEDIAL PLAN

EXECUTIVE SUMMARY OF REMEDIAL PLAN

The organization of this plan places the Executive Oversight Committee (state and plaintiff representatives) as the group with the ultimate responsibility of overseeing the progress of the plan and making recommendations to the court. However, the Steering Panel (providers, advocates, state and plaintiff representatives, managed care entities, Centers of Excellence) are the group with the expertise to provide input from many different perspectives for the direction of this plan. The Panel will oversee a needs assessment, direct the development of a data system, monitor progress and make recommendations to the Executive Oversight Committee for development of a system that will meet the health needs of these children. The Implementation Team (administrator, pediatrician, and child psychiatrist) will provide not only staffing for the above two groups, but will be involved in negotiating the contracts, providing options for best practice guidelines, and overseeing operational details that must be established between the partners/stakeholders to carry out this plan. They also have a role with those children at risk of coming into custody by determining if services denied by a BHO are to be implemented while awaiting the results of an appeal.

The Centers of Excellence (COE) are academic medical centers. They have always been safety net providers and will continue to be used in this manner while services are being developed in communities across the state. The difference in this plan is that the COE will have the final determination of whether children in custody receive services and an established mechanism that will allow them to get paid for all services performed. This reimbursement will be from managed care entity or the state depending upon the result of the appeal process. Since Behavioral Health Services are the emphasis of this plan, contracts with the COE will provide funds to enhance their capacity in this area as well as support infrastructure staffing. However, it is not the intent to rely on the COE for all services, but to develop as many services as feasible close to where children live. The COE can help train providers willing to care for these children and offer backup and consultations to health providers in the community.

The Best Practice Network is a group of providers willing to take on the added responsibilities of children in custody. The Primary Care Providers (PCP) will receive additional reimbursement for initial EPSDT exams and case management (which is paid directly to TennCare). Behavioral health providers will also receive an enhancement amount for a behavioral health screening, (which is more of a structured interview and is not to be confused with psychological testing).

The Best Practice Network pediatricians or family practice physicians caring for these children, agree to attend training, to coordinate all the health information, to work with the Department of Children's Services (DCS), the family, any community agencies, etc.... for the benefit of the child. DCS has the ultimate responsibility for the custody of the children but the job of the PCP is health case management. Behavioral health providers will also be offered free training. All providers will be expected to follow Best Practice Guidelines once such guidelines are adopted by the Steering Panel.

When a child comes into custody, the EPSDT exams are arranged as rapidly as possible, because the problems discovered on these exams will guide what services the child receives. If there are not problems, or only problems which can be handled by the local primary care, behavioral care, and dental providers, then no referrals will be necessary. If a child has a severe problem that local providers are unable to diagnose or treat, then a referral will be made to a specialist in the Best Practice Network in the area. If a specialist with appropriate training and experience is not available, only then will the child be referred to the COE. When providers involved with EPSDT exams or specialists in the area order a service that is denied by a MCO/BHO, they can contact the COE for a determination of whether the service can be initiated even while an appeal pending.

Children at Imminent Risk or Serious Risk of state custody can be offered: (1) evaluations at Primary Treatment Centers under contract with DCS if a residential setting is necessary; or (2) DCS case management and family preservation services while behavioral health services are being arranged. When the MCO/BHO denies services felt to be necessary, the Implementation Team can approve the initiation of the services before an appeal is decided.

CHART FOR REMEDIAL PLAN FOR CHILDREN IN CUSTODY

EXECUTIVE OVERSIGHT COMMITTEE (state and plaintiffs reps, facilitator, one COE rep)
Function: Monitor overall progress of plan and make recommendations to court

CHILDREN'S SPECIAL HEALTH NEEDS STEERING PANEL
(COE's, providers, managed care, State and plaintiff reps, advocates)
Function: Direct needs assessment and development of a data system
Approve Best Practice Guidelines
Monitor adequacy of system and recommend process for doing this
Make recommendations to Executive Oversight Committee for improvements/changes

IMPLEMENTATION TEAM (Administrator, pediatrician, child psychiatrist)
Function: Staff the Executive Oversight Committee and Panel
Pull together information for needs assessment, data system, best practice guidelines.
Resolution of payment issues for TennCare covered services for children at risk of custody.*

SERVICES:

CENTERS OF EXCELLENCE (5)

Provide care and consultations
Assist in coordinating appointments
Resolution of payment issues for TennCare covered services *
Provide some training to health professionals
Serve on Panel

BEST PRACTICE NETWORK (IN COMMUNITIES)

SPECIALISTS IN AREA

EPSDT EXAMS & CARE

PRIMARY CARE
Coordinate health services
Maintain all health records
Work with DCS/family
Work with COE in providing care to children

BEHAVIORAL PROVIDER

DENTAL

PRIMARY TREATMENT CENTERS
Diagnosis & Treatment in residential setting for children in custody & at Imminent & Serious Risk

DEPARTMENT OF CHILDREN'S SERVICES

Maintains final responsibility for children in custody & care plan
Arranges EPSDT exams when enters custody
Case management (custody children and those transitioning)

* Resolution of payment issues for TennCare covered services – When BHO/MCO denies [illegible] provider in Best Practice Network or COE, the COE has the authority to review the case and determine whether services can be initiated while an appeal is being filed. Any services initiated will be reimbursed by the responsible managed care organization or the state depending upon the outcome of the appeal. The Implementation Team assumes this role for children at Imminent or Serious risk of custody.

REMEDIAL PLAN FOR CHILDREN IN STATE CUSTODY

I. PRINCIPLES

A. Children in state custody often have a greater incidence of physical, behavioral, and developmental problems. This is a plan which begins the development of a system that provides the services needed for these children and offers a process for making changes and improvements. This plan and process are guided by the following principles:

1. Complete EPSDT screening exams are needed on entrance into custody to allow for appropriate planning of any care that might be needed.
    a. Screenings done by the primary care provider encompass physical and developmental components using tools approved by EPSDT advisory committee. Since a behavioral health provider will also be screening children in custody (except for infants, which for the purposes of this plan will be defined as birth to the second birthday,) the primary care provider will do only behavioral health screening that is important for his/her own case management needs.
    b. Dental screenings will be arranged with dentists.
    c. A more in-depth behavioral health screening should be done by a behavioral health provider unless the child is an infant and no useful information can be gained from such a screening. A more comprehensive screening tool will be developed by the CSHN Steering Panel.
2. Appropriate care should be provided as close to the place of residence as possible and build upon the patient's and family's strengths and needs.
3. Specialty and dental care should be available to meet all needs of these children.
4. Service coordination or case management is a critical component for any health system of children in custody or at imminent risk of entering custody - both while the child is in custody and during the phase of transitioning out of custody.
5. A health system for children in custody should be designed to allow for evaluation of the system as well as health outcomes of the children it serves.
6. The flow of health information within the system must allow for providers, DCS, and MCOs/BHOs to appropriately manage the care of children.
7. The system must include a sufficient array of services to assure that a child's needs are met on an individualized basis building upon the child's and family's strengths and, to the degree possible, furthers the goals of the permanency plan.
8. As the system is developed, Best Practice Network Providers will be created and Best Practice Guidelines will be established and followed.
9. Since behavioral health issues are prevalent in this group of children, emphasis should be placed on this component of care.

10. Centers of Excellence for children's services should have a far greater appreciation for this population's health needs based on their medical expertise and role in the medical community at large.
11. The input of caregivers is needed to design a system for children in custody.
12. Unmet needs of TennCare eligible children for health/behavioral health services should not influence legal custody status.
13. All parties having a role in the provision of health/behavioral health services will act as an integrated, collaborative team collectively serving in the best interest of the child, including but not limited to the Best Practice Network providers, COE, MCOs, BHOs, and DCS.

B. The TennCare Bureau, Department of Children's Services, tertiary pediatric centers, private physicians and mental health providers, and the Departments of Health and Mental Health propose a collaboration to develop, implement and maintain a system which will meet all the challenges and live up to the principles stated. It is the objective of this plan to have a comprehensive system of physical, behavioral and dental health services available to meet the needs of custody children by the end of Year 2.

II DEFINITIONS

A. *"Centers of Excellence"* (COE) are tertiary care centers that possess, or are in a position to quickly develop, expertise in pediatrics, child behavioral health issues (including aggression, depression, attachment disorders and sexualized behaviors) and the unique health care needs of children in custody. (The five tertiary pediatric sites which currently are tertiary care centers for pediatrics and will be considered to perform functions of the COE are in Johnson City, Knoxville, Chattanooga, Nashville, and Memphis. This does not preclude other sites being designated if later determined to be important to the system of care.)

B. The term *"Best Practice Network"* (BPN) refers to a group of providers (primary care, behavioral health, and dental) who have the interest, commitment, and competence to provide appropriate care for children in custody, in accordance with the terms of this Remedial Plan and statewide Best Practice Guidelines and have agreed to be in MCO or BHO network.

C. The term *"Children with Special Health Needs Steering Panel"* (CSHN Steering Panel) refers to an entity comprised of those members identified in this Remedial Plan whose responsibility will be to advise concerning the development of a health service system for children in state custody.

D. The *"Executive Oversight Committee"* is composed of representatives from TennCare, Department of Children's Services, plaintiff's attorneys, defendant's attorneys, a representative from the Centers of Excellence, and an agreed-upon consultant. It will have primary oversight for the implementation of this plan.

E. *"Medically necessary"* (definition in MCO and BHO contracts as read consistent with the *John B.* Consent Decree.)

F. *Screenings* - the initial examinations (physical, behavioral, and developmental) to determine if there are problems, or suspected problems.

G. *Assessments* - used in this document to mean an examination of a more diagnostic nature after a screening examination detects a real/suspected problem.

H. The term *"at imminent risk of entering custody"* shall mean those children who are at risk of entering state custody as identified by a court pursuant to Title 37, Tenn Code Ann.

I. As used in this plan, *"covered services"* refer to TennCare covered medical and behavioral health services. The term "covered services" does not include services that:

1. Are subject to an exclusion that has been reviewed and approved by the Federal Health Care Financing Administration and incorporated into a properly promulgated state regulation: OR
2. Under Title XIX of the Social Security Act, are never federally reimbursable in any Medicaid program.

III. ESSENTIAL COMPONENTS OF HEALTH CARE SYSTEM

A. Centers of Excellence

1. Centers of Excellence are pediatric tertiary care sites presently functioning in Tennessee. These pediatric tertiary care sites will serve as Centers of Excellence (COE) for this health system. These sites already provide referral services for children and youth because of the expertise they have for physical and developmental health problems of this age group. During the first year of operation the centers will function in their usual capacity to provide tertiary care and consultations for the children with the most severe problems assisted with funds to help them build their behavioral health capacity and provide the coordination of appointments. During this first year of operation they will appoint a representative to serve on the CSHN Steering Panel which will explore additional functions or activities that might best be performed by the COE. Should the CSHN Steering Panel recommend additional activities for the COE, and these are approved by the Executive Oversight Committee (see Steering and Monitoring), or should the Executive Oversight Committee recommend additional activities for the COE, then negotiations will occur with the centers for these to be done. While the state agrees to contract with the COE for at least three years, any new requests for services from the COE will require additional negotiations with the centers and only be initiated if the COE is in agreement.
2. Role of Centers of Excellence - The COE will play different roles in the care of custody children. For one group with severe problems, they will provide all, or the majority of, on-going care when local providers request this; for another group they may provide diagnostic services only, or, continue occasional consults to the providers managing these children's

remaining children in custody may have no direct contact with the COE but may benefit from the training offered to providers as well as the benefits derived from representatives serving on the CSHN Steering Panel.

3. The COE will:

a. Recommend statewide Best Practice Guidelines to CSHN Steering Panel (the COE are not expected to develop these guidelines, but the representatives on the CSHN Steering Panel will be asked to review existing examples and approve the Best Practice Guidelines to be used in this system. These will be reviewed and revised periodically as needed.)

b. Provide training and in-service to Best Practice Network (BPN) and DCS providers and staff. The COE can work as a group to provide training on a statewide basis to avoid duplication of effort.

c. Provide specialized tertiary care services including multidisciplinary evaluations; develop specialized health treatment plans; provide tertiary care coordination of the health services ordered; and provide ongoing specialized health care to children when that level of care is indicated.

d. Representatives on the CSHN Steering Panel will participate in directing a system needs assessment conducted by the CSHN Steering Panel inclusive of educational needs of participating and non-participating providers, agencies providing services for children with special needs, availability of a continuum of services for children in custody, and other components as determined by the COE or the CSHN Steering Panel.

e. Provide a representative to assist DCS in developing protocols for direct referral to the COE, rather than a DCS Diagnostic and Evaluation Center (which will transition to become the Primary Treatment Centers), for certain exceptional cases.

f. Coordinate appointments for referrals and telephone consultations for specialized care for custody children, including notification of the BHO and MCO.

g. Provide follow-up contacts with caregivers, providers, and DCS to assure compliance with care plans of children seen at the COE.

h. Provide consultations to BPN and DCS providers on special needs children (health and behavioral health).

i. Assist in the recruitment of BPN providers.

j. Act as safety net providers for health and behavioral health needs of children in custody; assess the system to recommend strategies to strengthen the local health care system to decrease the need for the safety net function.

k. Participate (through the representative on the CSHN Steering Panel) in developing a quality assurance process for the system.

l. Provide faculty members to evaluate cases where services are ordered by BPN provider (including the COE) but are denied by BH[illegible] COE staff will recommend whether covered services ar[illegible]

necessary. (See § III(D)(4).)

m. Determine when specialist can serve as PCP on special cases where this is deemed in the child's best interest and the specialist is willing to accept this role. If an MCO already has a mechanism established allowing a DCS case manager to determine this, the COE does not have to be contacted.

B. Best Practice Networks

1. There will be two categories in the BPN:
   a. The primary care providers (PCP) who not only administer basic health care, but also coordinate all physical and behavioral health care of each child assigned to them. They maintain all health records on each child they serve, whether the care was provided by the COE, another specialist in the BPN, or a behavioral health provider.
   b. Specialty health, behavioral health and dental providers who will be recruited for the Best Practice Network to have easy access to services, but will not have the case management responsibility of the PCP.
2. The responsibility to maintain an adequate network of providers remains with the MCO/BHO. However, it is recognized that children in custody often have a greater need for behavioral health services than the general population and require types of services not utilized frequently enough to be found in all communities.
3. Adequate Capacity. The MCO/BHO must maintain a provider network with adequate capacity to deliver covered services which meet the special needs of children in state custody. Indicators of an adequate network for these children include:
   a. The MCO/BHO meets the guidelines established by its contract with TennCare for a provider network;
   b. The MCO/BHO has enough providers to consistently meet the time lines of this plan for EPSDT screenings;
   c. The MCO/BHO has sufficient providers to be able to consistently deliver services ordered by a provider in its own network, a Best Practice Network provider or a COE within the time frame requested; and
   d. The MCO/BHO has within its network specialized health providers with sufficient expertise to deliver the covered services recognized in Best Practice Guidelines as being proven effective and needed by children in custody.
   e. TennCare will include language consistent with the above criteria in the next contract with managed care entities.
4. Failure to Maintain Adequate Capacity in Network and Recruitment of Best Practice Network Providers. The state or the COEs will recruit for the Best Practice Network providers who have appropriate credentials, [illegible] follow BPN guidelines and are willing to participate in MCO [illegible]

The MCO/BHO must contract with all BPN providers unless it can demonstrate to the Implementation Team that its existing network is adequate. If an MCO/BHO can demonstrate to the satisfaction of the Implementation Team that its network partially satisfies the adequacy requirements listed above (e.g., in a particular geographic area or medical specialty), but not entirely, the Implementation Team, in its discretion, can excuse the MCO/BHO from contracting with BPN providers in those areas in which the MCO/BHO's network is adequate. Consistent with the regulatory framework established by this plan, decisions made by the Implementation Team pursuant to this part are ultimately subject to review by the Executive Oversight Committee.

5. Safety Net. While the primary care BPN is being developed, DCS will continue to use the MCO/BHO providers who now serve their children. As the network is developed, DCS will arrange for screenings and care to be provided by BPN primary care providers. The 95 county health departments will serve as a safety net for EPSDT screenings during the first year when these cannot be obtained through private providers, either inside or outside of the BPN. The local health departments will be considered for PCP in BPN during the first year when other providers cannot be obtained and in the areas where primary care is available.

6. Behavioral Network. An adequate number of behavioral health professionals with appropriate expertise for custody children will be contracted by the BHOs to provide the behavioral health screenings and assessments as well as the medically necessary care that will be needed. It will be the rule rather than the exception, to screen all children coming into custody by behavioral health providers in the Best Practice Network. Only infants will be excluded from seeing a behavioral health provider. A child that is already demonstrating signs or symptoms of a behavioral health problem may be referred directly for a behavioral health assessment/care by the PCP without taking the time to get a behavioral screening. Behavioral assessments will be conducted as deemed clinically appropriate by the behavioral health professionals doing the screenings.

7. Role of the Primary Care Provider in Best Practice Network:
   a. Provide EPSDT screenings and make referrals for behavioral screenings.
   b. Provide not only the basic health care, but also care coordination of all the health care services (physical and behavioral) of each child assigned to them.
   c. Refer to local physical and behavioral health professionals in Best Practice Network for specialty care; refer to the COE for specialty care when indicated; coordinate referrals with MCO/BHO.
   d. Request telephone consultations from the COE.
   e. Communicate with caregivers on plan of care.
   f. Maintain all health information on children assigned [illegible] of who provided the care (the COE, local specialist, [illegible]

provider); report to Health Unit of DCS any time health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care. (This will be done within the confines of the federal confidentiality laws. A protocol will be developed for the sharing health information among the providers of this system.) Forward medical files to the newly assigned PCP when a child is being transferred to a new geographical area; share health information with DCS and foster parents.

g. Forward pertinent information to providers seeing children on referrals.

h. Utilize (and document) Best Practice Guidelines for care when developed and adopted by CSHN Steering Panel and Executive Oversight Committee and document rationale for variation from Best Practice Guidelines.

i. Review information provided by state or the COE on caring for children in custody.

j. Participate in the evaluation of system and outcomes with the COE, MCOs, BHOs, and the CSHN Steering Panel.

k. Participate in TennCare MCOs and BHOs serving their area.

l. Participate in training provided by the COE for health professionals serving these children, including but not limited to, health issues of children in custody and Best Practice Guidelines for physical and behavioral health.

m. For children with ongoing care needs (who are not receiving direct care from the COE and therefore will not have a health treatment plan developed by the COE), develop a health treatment plan and incorporate all the treatment needs of the child.

8. Incentives for recruitment of the PCP in the BPN will be:

a. A higher reimbursement rate for initial EPSDT exams;

b. A monthly case management fee in addition to what the MCO is paying the provider for their services;

c. Training and in-service provided by the COE; and

d. More efficient method for obtaining services from other providers for children. (See § III(D)(4).)

9. Role of the Behavioral Health Providers in Best Practice Network.

a. Provide initial screening when referred by PCP; provide behavioral assessments when clinically indicated.

b. Provide behavioral health care when children are referred.

c. Forward information from screenings, assessments, or care to PCP in BPN; forward information to the COE when requested; communicate information to BHO as requested to coordinate care. (It will be determined later whether it is logistically better for the behavioral health provider to send results of exams and treatment to DCS or let the PCP do this, but it is understood that the behavioral health provider will communicate directly with DCS and the PCP as indicated.

and well being of the child.)

d. Offer input on Best Practice Guidelines.

e. Utilize Best Practice Guidelines when established and adopted by the system; document when a variation from the Best Practice Guidelines is indicated.

f. Assist TennCare and BHO in evaluating the system and care.

g. Participate in TennCare and BHO as contracted provider.

h. Review information received from state and the COE on how to best provide care for children in custody.

i. Participate in training provided by the COE including but not limited to behavioral health problems of children in custody and Behavioral Best Practice Guidelines.

j. Coordinate care with BHOs in the form eligibility checks, and concurrent review/development of treatment plans when indicated.

k. Participate in development and implementation of health treatment plans for children they serve.

10 Role of Primary Treatments Centers (PTC).

a. Transition. DCS is responsible for transitioning the Diagnostic and Evaluation Centers to Primary Treatment Centers (PTC) over the next year. (It is understood that the D & E Centers at this time do not have the capability that this plan requires but that DCS will be working with them to develop this capability.) TennCare will require the BHO to contract with these providers and DCS will require that PTCs contract with the BHO. Children referred to PTCs are children who have just come into custody, children already in state custody, children who have been released from state custody and have been recommitted, and children who are at imminent risk of entering custody. (See CHILDREN DEFINED BY STATUTE AS AT IMMINENT RISK OF COMING INTO CUSTODY).

b. Children Served:

(1) The children at these centers will be served according to their individual service needs. Children may be dependent/neglected, adjudicated on non-felony delinquent charges, unruly, or abused; Children may display chronic runaway behavior, manipulative behaviors, have difficulty maintaining self-control, display poor self esteem, be habitually truant from school, have difficulty accepting authority; Children may have Level II or Level III substance abuse needs; Children may have been adjudicated on felony delinquent charges but not pose a significant community safety risk, indicating the need for detention or Youth Development Center services.

(2) PTCs will serve children who have been found to [illegible] are alleged to be delinquent based upon a felony or

constituting a crime against a person or persons; youth who have prior commitment to the Department of Children's Services as a result of having committed a felony offense or offenses which constitute a crime against a person or persons; youth who are found to be delinquent or are alleged to be delinquent based upon a felony drug offense; youth who have prior commitments to the Department of Children's Services as a result of having committed a felony drug offense and youth who have a history of prior convictions for felony offenses, it appropriate for the service and not a community safety risk, providing total separation in all housing and programming between these children and children who are not adjudicated delinquent due to felony offenses against person or felony drug offenses in their present or prior commitments. Issues related to safety of non-custodial children at PTCs will be monitored by a consultant to be mutually agreed upon by both parties.

c. Assessments. The PTC will have psychological as well as psychiatric services available for the assessment and treatment of children in their care. As part of the PTC they can consult and refer to the COE. They will also be able to provide initial and ongoing treatment to children/youth while conducting assessments and/or psychological evaluations to identify treatment and/or placement needs. Assessments will be completed as quickly as possible but must be completed within 21 days for these children at imminent risk of entering custody.

d. Services. PTCs are currently being developed and are expected to begin providing services on July 1, 2000. The following services are considered to be within the scope of services of the PTCs at this time, but may be subject to change as the implementation of this model proceeds, with approval of the CSHN Steering Panel and the Executive Oversight Committee:

(1) Respite care services limited to 48 hours to allow a cooling-off period between family members during the period of home based observation, treatment and assessment services.

(2) Foster family based observation, assessment and treatment for children and youth who exhibit behavioral, emotional or social problems that prevent in-home assessment or who do not have family members to provide appropriate in-home care due to the nature of the petition for removal.

(3) Observation, assessment and treatment in group setting for children who cannot remain at home and who are inappropriate or disrupt from a foster family placement during the evaluation service.

e. Facility requirements regarding safety for these children include

(1) 24 hours awake staff

(2) 1:8 ratio during awake hours of direct care staff to children

(3) At night one awake staff for each eight children and youth enrolled

f. Facility requirements for secure centers for children with significant alcohol and drug issues and behavioral/mental health needs requiring this level of supervision/staffing:

(1) 24 hour awake staff

(2) 1:5 ratio during awake hours of direct care staff to children

(3) At night at least one awake staff for each 5 children and youth enrolled

g. Reimbursement will be covered in accordance with § III(D)(4).

11. Role of Other Providers in Best Practice Network.

a. Dental providers will do screenings and provide care to children in custody; share health information with PCP; participate in TennCare MCOs in the area.

b. Medical specialists will provide assessments and care when referred by PCP; share health information with PCP; participate in TennCare MCOs in the area; follow Best Practice Guidelines when developed; participate in evaluation of system and care of children.

C. Managed Care and Behavioral Health Organizations

1. Since TennCare MCOs and BHOs are critical to the success of this remedial plan for children in custody, there will be one representative from the MCOs and one from the BHOs included on the CSHN Steering Panel.

2. Role of MCOs and BHOs.

a. Participate on CSHN Steering Panel through one MCO representative and one BHO representative who have appropriate expertise in pediatric health and behavioral health issues.

b. Recruit and contract with adequate number of providers for Best Practice Network.

c. Develop procedures for assigning children in custody to BPN PCPs.

d. In accordance with § III(B)(3), assure that networks are adequate and meet the TennCare contract standards of access and availability; work collaboratively with the CSHN Steering Panel and the COE to recruit providers where needed.

e. Assist in developing Best Practice Guidelines.

f. Continue to manage and be responsible for all aspects of the TennCare program (for MCOs) and TennCare Partners program (for BHOs) as specified in contracts with TennCare.

g. Contract with the Primary Treatment Centers.

h. Share with the COE utilization guidelines used by each managed care entity to improve understanding and cooperation between the COE and MCO/BHO. The definition of "medical necessity" in the [illegible]

contracts will be the standard of what is needed by children, however, and not utilization guidelines.

D. TennCare Bureau Responsibilities

1. Provide direct reimbursement for initial EPSDT screenings (medical, dental, and behavioral).
2. Provide a per member/per month case management fee to PCP's in BPN for custody children.
3. Develop a mechanism for timely payments to service providers for the process covered below when the expedited appeal is determined in favor of the MCO/BHO.
4. Resolution of Payment Issues for TennCare Covered Services.
   a. If, for a child it is treating or diagnosing, the COE orders a TennCare covered service which is felt to be medically necessary, then:
      (1) The BHO/MCO is contacted by the COE provider (when prior authorization required) and the covered service is denied;
      (2) If the COE is convinced that the covered service requested and denied is a medically necessary TennCare service, then it can begin the service or arrange for a provider in the MCO or BHO network to begin the service; the provider to be utilized will be discussed with the MCO/BHO to assure that they are still a participant and in good standing with the managed care entity.
      (3) The state will establish the process whereby, the provider chosen in C above, (when not the COE) will receive written authorization to provide the service to assure reimbursement.
      (4) The COE initiates an expedited appeal for the service if the service is to be provided by the COE.
      (5) If the appeal is decided against the managed care entity, the BHO/MCO will pay for the service. If the appeal is decided for the managed care entity, TennCare will pay the provider for the service.
   b. If a BPN provider requests a service that requires prior authorization and the service is denied by the MCO/BHO, then:
      (1) The BPN provider contacts the COE and reviews the case with a faculty member for medical necessity;
      (2) If the COE concurs with the MCO/BHO that the service is not medically necessary or not covered, the COE will work with the BPN provider to determine an alternative, but appropriate service to order.
      (3) If the COE concurs with the BPN provider that the ordered service is covered and medically necessary, then the COE will contact the MCO/BHO for approval.
      (4) If the MCO/BHO denies the service, the COE can be [illegible]